Indiana Foster Family

Resource Guide

INDIANA DEPARTMENT OF CHILD SERVICES

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FOREWORD

The Foster Family Handbook has been renamed the Foster Family Resource Guide.

The purpose of this guide is to provide further insight into areas of foster parenting that will be most helpful to foster parents. The information may be new in some instances and may serve as a reminder in others.

All policies and procedures are now available on the DCS Website, ***http://www.in.gov/dcs/***, and you can have access to the site from your home computer, a library or other public access site. There are new policies and procedures for licensing in Chapter 12, Foster Home Licensing. New policies and procedures relating to children in out of home care are in Chapter 8, Out of Home Services.

Throughout this Guide, links to related policies are listed by policy name and web address where possible. Currently, all child welfare policies, not just those that pertain to foster parenting, are being reviewed, updated, and rewritten in a simplified format; therefore, when you access the website, some policies will appear in the new format and the remainder will appear in the format previously used. If you are reading this Guide online, when you see a web address that is highlighted, put your cursor over the address, press and hold the Control key (CTRL) and left click the mouse and you will go directly to that policy.

Acknowledgements

We greatly appreciate the contributions foster parents have made to the revisions of this handbook over the years. It is a product of collaboration among foster parents, family case managers, community representatives, public and private agency staff, and State and Local Department of Child Services.

Mission, Vision, & Values of the Indiana Department of Child Services

Mission:

The Indiana Department of Child Services (DCS) protects children from abuse and neglect. DCS does this by collaborating with families and communities to provide safe, nurturing, and stable homes.

Vision:

Children thrive in safe, caring, supportive families and communities.

Values:

- We believe every child has the right to be free from abuse and neglect.
- We believe every child has the right to appropriate care and a permanent home.
- We believe parents have the primary responsibility for the care and safety of their children.
- We believe the most desirable place for children to grow up is with their own families, when these families are able to provide safe, nurturing, and stable homes.
- We believe in personal accountability for outcomes including one's growth and development.
- We believe every person has value, worth, and dignity.

Bill Of Rights For Foster Children

Every foster child has inherent rights:

Article I:

To be cherished by a family of their own, either by having their family helped by readily available services and supports to resume their care, or by plan, a continuing foster or adoptive family.

Article II:

To be nurtured by foster parents who have been selected to meet their individual needs and who are provided services and support, including specialized training, so that they can grow in their ability to enable the foster child to reach their potential.

Article III:

To receive sensitive, continuing help and understanding in accepting the reasons for their own family's inability to take care of them and in developing confidence in their own self-worth.

Article IV:

To receive continuing, loving care and respect as a unique human being—so they grow to trust in themselves and others.

Article V:

To grow up in freedom and dignity in a neighborhood of people who accept them with understanding, respect and friendship.

Article VI:

To receive help in overcoming deprivation or whatever distortion in their emotional, physical, intellectual, social, and spiritual growth may have resulted from their early experiences.

Article VII:

To receive education, training, and career guidance to prepare them for a useful, satisfying life.

Article VIII:

To receive preparation for citizenship and parenthood through interaction with foster parents and other adults who are consistent role models.

Article IX:

To be represented by an attorney-at-law in administrative or judicial proceedings with access to fair hearings and a court review of decisions, so that their best interests are safeguarded.

Article X:

To receive quality services, including involvement of the child and the legal parents in major decisions that affect their lives.

Article XI:

To be allowed to visit with their legal parent(s) if they are in foster care.

Article XII:

To have contact with siblings and other relatives.

Bill Of Rights For Foster Parents

Because foster parents provide such important services to the child welfare system and their participation in the foster care team requires complete dedication, it is important that there be rights to which they are entitled when providing foster care.

As Resource (Foster/Relative) Parents you have the right to:

1. Accept or refuse placement of a child into your home;
2. Receive foster care per diem to help meet the needs of the child;
3. Have a clear understanding of your role as foster parents and the Department's role;
4. Continue your family traditions, routine, religion, morals, and values, as long as they do not infringe on the foster child's rights;
5. Receive information concerning the foster child that has direct bearing on the child's daily living, as well as any potential dangers from the child or the child's family, including medical, psychological, and other documents that will help serve the best interest of the child;
6. Have input into the visitation plan for the child and the child's family;
7. Have input into the child's case plan and on-going planning for the child, especially in areas that will affect the care you provide for that child;
8. Help reunite the family by caring for the child temporarily;
9. Receive respect and support, and be recognized as a partner in all interactions with the Department;
10. Make decisions concerning daily living situations such as permission to attend recreational activities and staying home sick from school;
11. Get help from the family case manager with locating and using appropriate resources to meet the child's needs;
12. Receive proper and timely notification of court hearings, family visitations, and other medical visits;

13. Provide information to the court about the child in your care;
14. Utilize respite care when needed;
15. Be considered as the long-term placement for the child in the event the child is to be placed in long-term or permanent foster care;
16. Be considered as adoptive parents for a child in your care in the event in which parental rights are terminated;
17. Ask questions or voice opinions about the child's situation without reprisal from the family case manager or the Department;
18. Receive adequate notification in the event of a removal of a child;
19. Have information concerning your family kept confidential except when that information is considered public record;
20. Encourage the Department to place children in your home;
21. Request a written explanation from the Department if it does not place children in your home.
22. Know the appropriate appeal process in the event of a disagreement with the Department.

Responsibilities of The Department of Child Services

The following are responsibilities the Department of Child Services assumes when placing children in a foster home:

1. Reasonably assist the foster parent in maintaining their foster care license issued by the DCS, including the provision of required training, while treating the foster parent with respect and appreciation.
2. Make available current licensing rules and written guidelines of the DCS and ensure compliance with the written requirements.
3. Provide an explanation of the DCS policies on discipline, matching, foster parents' role, visitation, and the Department's role and responsibility.
4. Provide an explanation of the DCS case conferencing policy which operates on the basis of shared and clarified information between the DCS and foster parent and requires the involvement of the foster parent in case plan development and change. This policy also includes a procedure for resolving conflicts between foster parent and the DCS.
5. Provide foster parents with the names and phone numbers of family case managers and a copy of the DCS or LCPA policies and procedures related to notification, including a plan for emergency "after hours" contact.
6. Provide information, education, and training on cultural awareness and promote cultural and minority sensitivity.
7. Provide information regarding a child's religious preference, if known.
8. Provide foster care per diem, clothing allowance, and necessary dental, optical, and medical expenses and arrange for any other special medical or psychological services.
9. Secure the proper authorizations for the administering of any non-emergency treatment to the child, and consult with and assist the foster parent in providing treatment or referring them to an appropriate service provider.
10. Provide an allowance for education needs including tuition in public schools, supplies, rental fees and any approved fees for supplemental education. This may or may not be a part of the per diem to the foster home in your county.

11. Develop an individual case plan for each child in foster care, with input from the foster parent. The plan is shared with the foster parents so that they are familiar with the case goals and specific needs of each child placed in the foster home.
12. Provide a copy of the child's Case Plan (which defines appropriate discipline for a child in foster care) and Visitation Plan.
13. Assist in arranging visitation and encourage communication between the foster children and the legal parents or other appropriate individuals. The DCS will provide such notice as is proper to the foster parent under the circumstances.
14. Monitor and supervise the implementation of the case plan, making face-to-face contact with the child and the foster parent according to the service level as the case dictates.
15. Consider input from foster parents and other appropriate persons and make final decisions concerning the care and well-being of foster children, within the legal framework established for the DCS.

Foster Parenting

Reasons to Immediately Notify DCS

Notify the DCS OFFICE IMMEDIATELY when any of the following occurs:

1. A serious injury or illness involving medical treatment of the child;
2. A serious emotional or behavioral crisis that may endanger the child or others;
3. The child has been the victim of abuse or neglect, has been the victim of assault or other physical or sexual abuse, or has been a perpetrator of any of these;
4. The death of a biological or foster child;
5. Unauthorized absence of the child from the home; runaway or truancy;
6. Removal of the child from the home by any person or agency other than the placing agency or persons authorized by that agency, or any attempts at such removal;
7. A fire or other emergency requiring overnight evacuation;
8. Any involvement of a foster child with police authorities or with school authorities regarding disciplinary or special education matters;
9. Plans to transport the foster child out of the state for any reason;
10. Pregnancy or impending fatherhood of a child;
11. A suspicion, or information, that the child is using drugs, tobacco or alcohol;
12. Report changes in any medication that the child is taking,
13. Household composition changes as in a separation or divorce or an adult moves into the home.

Understanding the CHINS Process

Definition of a Child in Need of Services (CHINS)

A child is considered a "Child in Need of Services" if, before the child's 18th birthday, any of the following occur:

1. The child's physical or mental condition is seriously impaired or seriously endangered as a result of the inability, refusal, or neglect of the child's parent, guardian, or custodian to supply the child with necessary food, clothing, shelter, medical care, education, or supervision;
2. The child's physical or mental health is seriously endangered due to an injury by the act or omission of the child's parent, guardian, or custodian;
3. The child is a victim of certain sex offenses under I.C. 35-42-4-1, I.C. 35-42-4-2, I.C. 35-42-4-3, I.C. 35-42-4-4; I.C. 35-42-4-7; I.C. 35-42-4-9; I.C. 35-45-4-1; I.C. 35-45-4-2; I.C. 35-46-1-3; or the law of another jurisdiction, that is substantially equivalent to these Indiana codes; or the child lives in the household as another child who is the victim of the same sex offenses described above; or the child lives in the same household as the adult who committed one of the same sex offenses, and it resulted in a conviction or a judgment under I.C. 31-34-11-2.
4. The child's parent, guardian, or custodian allows the child to participate in an obscene performance (as defined by I.C. 35-49-2-2 or I.C. 35-49-3-2;
5. The child's parent, guardian, or custodian allows the child to commit certain sex offenses prohibited by I.C. 35-45-4;
6. The child seriously endangers the child's own health or the health of another individual;
7. The child's parent, guardian, or custodian fails to participate in a disciplinary proceeding in connection with the student's improper behavior as provided for by I.C. 20-33-8-26, if the student has been repeatedly disruptive in the school;
8. The child is a missing child (as defined by I.C. 10-13-5-4;
9. The child has a disability and is deprived of nutrition that is necessary to sustain life; or is deprived of medical or surgical intervention that is necessary to remedy or ameliorate a life threatening medical condition if the nutrition or medical or surgical intervention is generally provided to similarly situated children with or without disabilities;
10. The child is born with fetal alcohol syndrome, or any amount, including a trace amount, of a controlled substance or a legend drug in the child's body;

11. The child:

a. has an injury,

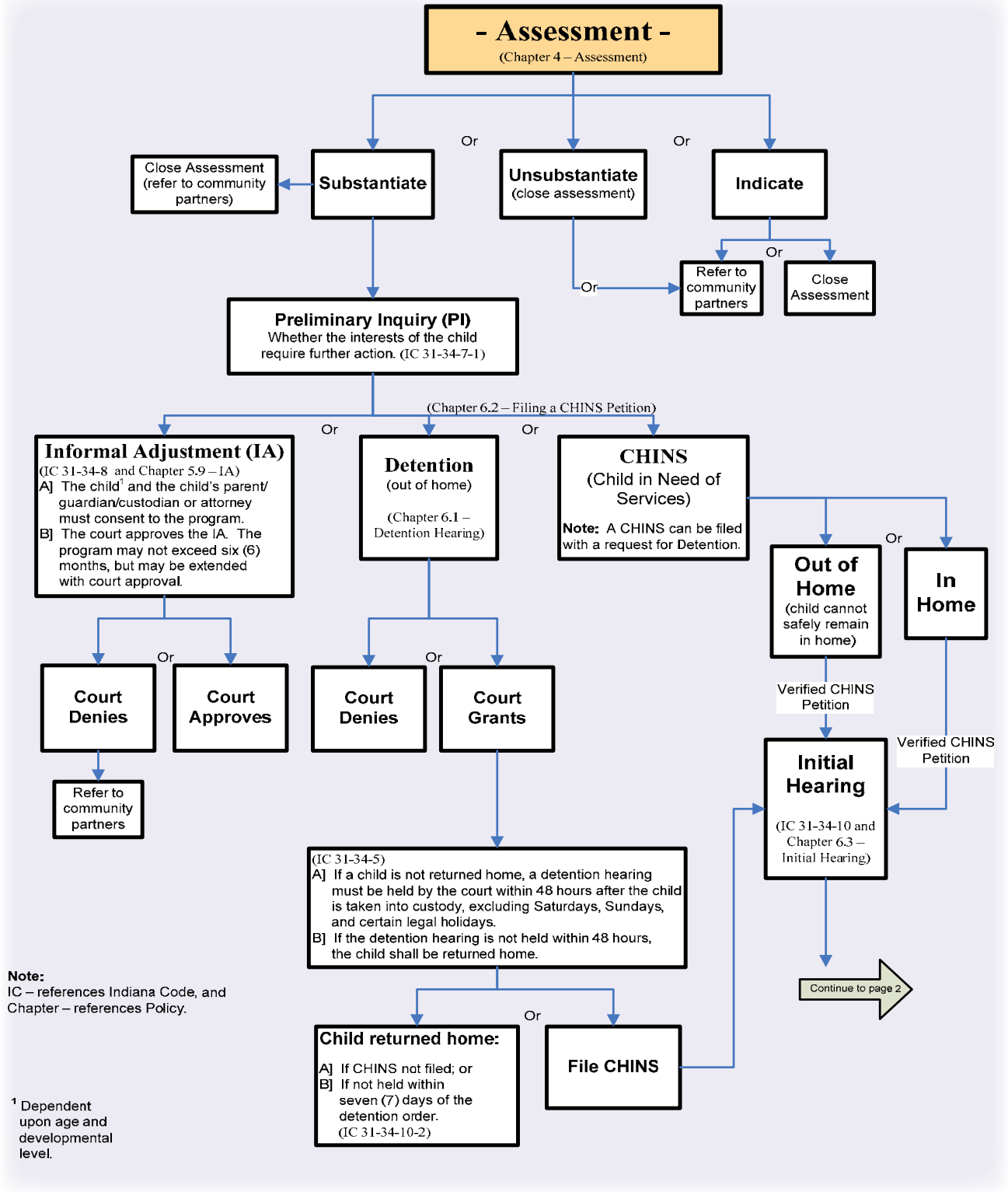
b. has abnormal physical or psychological development; or,

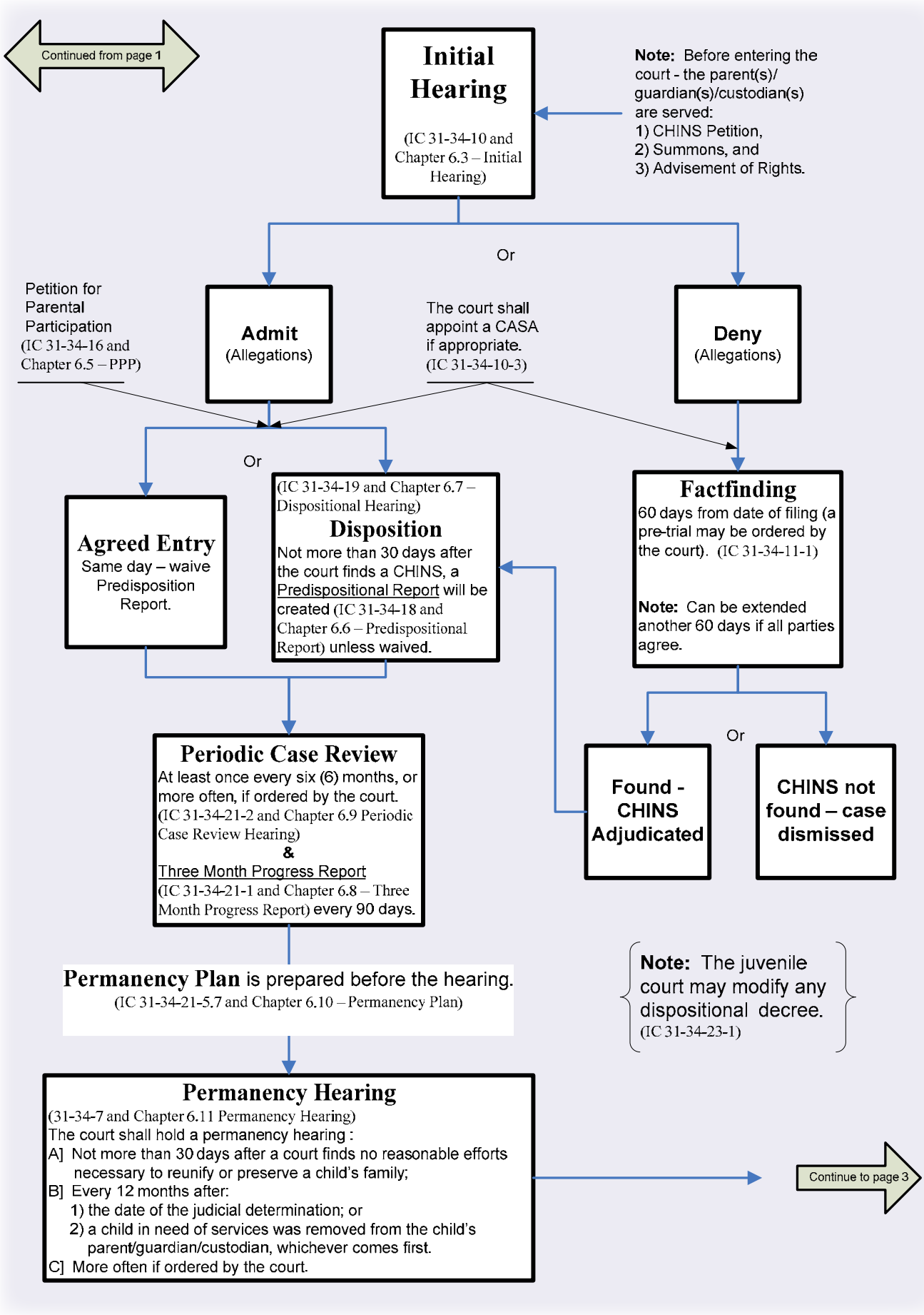
c. is at substantial risk of a life threatening condition;

that arises or is substantially aggravated because the child's mother used alcohol, a controlled substance, or a legend drug during pregnancy; and (for all but #6 above) the child needs care, treatment, or rehabilitation that the child is not receiving, and that is unlikely to be provided or accepted without the coercive intervention of the court.

Indiana Code 31-34: Article 34. Juvenile Law: Children in Need of Services
Chapter 3: Circumstances Under Which a Child is a Child In Need of Services
http://www.in.gov/dcs/files/cwmanual3.pdf

INDIANA DEPARTMENT OF CHILD SERVICES	INDIANA DEPARTMENT OF CHILD SERVICES CHILD WELFARE MANUAL	
	Tool Name: 6.A - Tool: Legal Process Overview	**Effective Date:** July 1, 2008
	Reference: Chapter 6	**Version:** 1

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Initial Hearing
(IC 31-34-10 and Chapter 6.3 – Initial Hearing)
Note: Before entering the court - the parent(s)/ guardian(s)/custodian(s) are served:
1) CHINS Petition,
2) Summons, and
3) Advisement of Rights.
Or
Petition for Parental Participation (IC 31-34-16 and Chapter 6.5 – PPP)
Admit (Allegations)
The court shall appoint a CASA if appropriate. (IC 31-34-10-3)
Deny (Allegations)
Or
Agreed Entry
Same day – waive Predisposition Report.
(IC 31-34-19 and Chapter 6.7 – Dispositional Hearing)
Disposition
Not more than 30 days after the court finds a CHINS, a Predispositional Report will be created (IC 31-34-18 and Chapter 6.6 – Predispositional Report) unless waived.
Factfinding
60 days from date of filing (a pre-trial may be ordered by the court). (IC 31-34-11-1)
Note: Can be extended another 60 days if all parties agree.
Or
Found - CHINS Adjudicated
CHINS not found – case dismissed
Periodic Case Review
At least once every six (6) months, or more often, if ordered by the court. (IC 31-34-21-2 and Chapter 6.9 Periodic Case Review Hearing)
&
Three Month Progress Report
(IC 31-34-21-1 and Chapter 6.8 – Three Month Progress Report) every 90 days.
Permanency Plan is prepared before the hearing.
(IC 31-34-21-5.7 and Chapter 6.10 – Permanency Plan)
Note: The juvenile court may modify any dispositional decree. (IC 31-34-23-1)
Permanency Hearing
(31-34-7 and Chapter 6.11 Permanency Hearing)
The court shall hold a permanency hearing :
A] Not more than 30 days after a court finds no reasonable efforts necessary to reunify or preserve a child's family;
B] Every 12 months after:
1) the date of the judicial determination; or
2) a child in need of services was removed from the child's parent/guardian/custodian, whichever comes first.
C] More often if ordered by the court.
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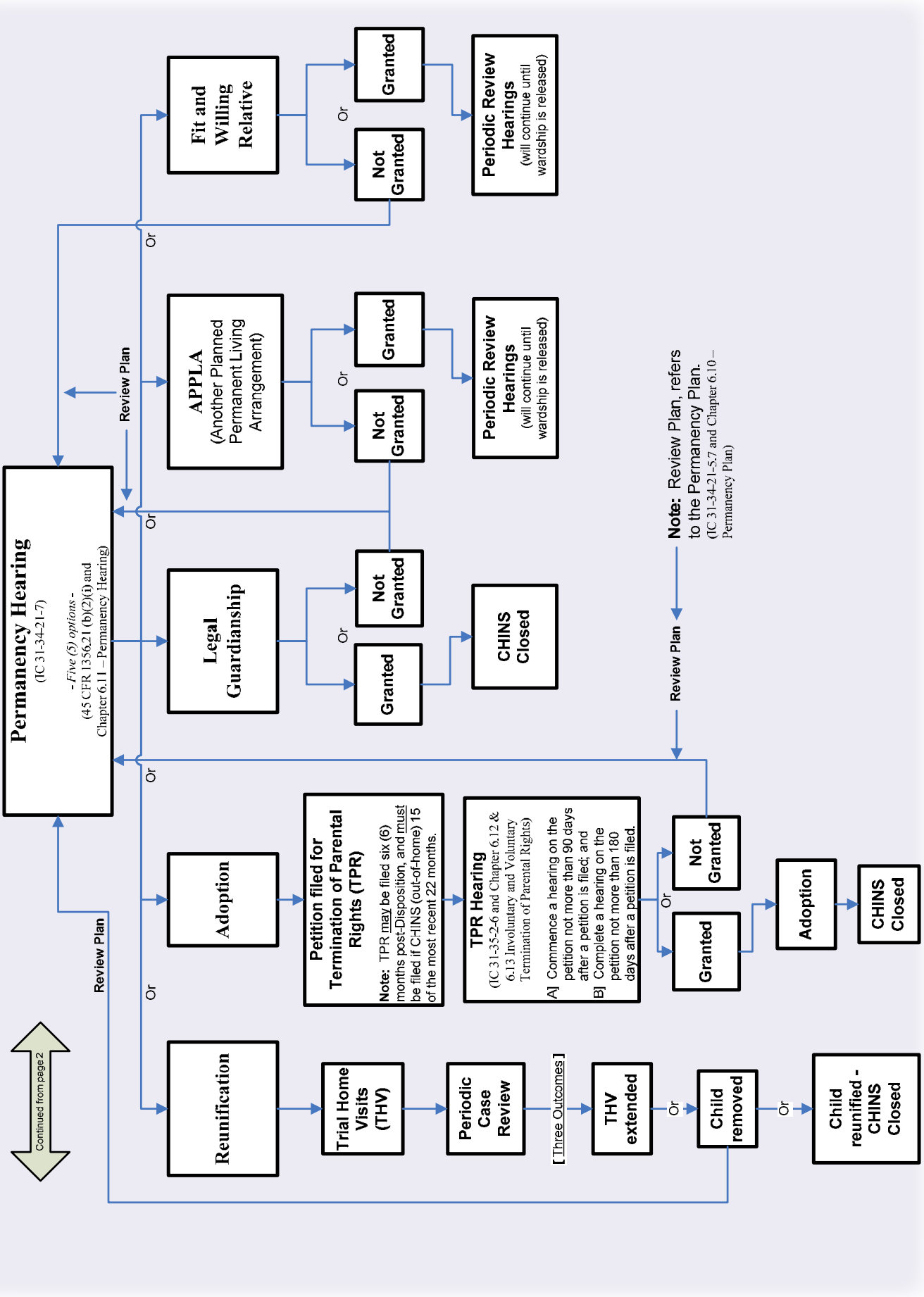
Permanency Hearing
(IC 31-34-21-7)
- Five (5) options -
(45 CFR 1356.21 (b)(2)(i) and
Chapter 6.11 – Permanency Hearing)
Review Plan
Fit and Willing Relative
Granted
Not Granted
Periodic Review Hearings
(will continue until wardship is released)
APPLA
(Another Planned Permanent Living Arrangement)
Granted
Not Granted
Periodic Review Hearings
(will continue until wardship is released)
Legal Guardianship
Not Granted
Granted
CHINS Closed
Adoption
Petition filed for Termination of Parental Rights (TPR)
Note: TPR may be filed six (6) months post-Disposition, and must be filed if CHINS (out-of-home) 15 of the most recent 22 months.
TPR Hearing
(IC 31-35-2-6 and Chapter 6.12 & 6.13 Involuntary and Voluntary Termination of Parental Rights)
A] Commence a hearing on the petition not more than 90 days after a petition is filed; and
B] Complete a hearing on the petition not more than 180 days after a petition is filed.
Not Granted
Granted
Adoption
CHINS Closed
Reunification
Trial Home Visits (THV)
Periodic Case Review
[Three Outcomes]
THV extended
Child removed
Child reunified - CHINS Closed
Or
Review Plan
Note: Review Plan, refers to the Permanency Plan.
(IC 31-34-21-5.7 and Chapter 6.10 – Permanency Plan)
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Child and Family Team Meetings

The Department of Child Services is changing the way it works with families involved in the child welfare system. There is a renewed commitment of social work practice that makes service and support to the child and biological family even more important. This commitment is family focused and the basic principle is that all families should be primary decision makers in their future.

Indiana has identified essential practice skills necessary to effectively carry out this process. These skills include engaging, teaming, assessing, planning and intervening.

Focusing on these five essential practice skills has allowed Indiana to begin using the Child and Family Team Meetings (CFTM) as its foundation for case planning and decision-making. The child and family team meeting is a process that brings together biological family members, resource parents, interested people (such as friends, neighbors, and community members of the family) and formal resources such as child welfare, mental health, education and other agency representatives to:

- Recognize and affirm family strengths
- Access family needs
- Learn what the family hopes to accomplish
- Find solutions to meet family needs
- Set reasonable and meaningful goals
- Develop and achieve a workable case plan for each child and family.
- Achieve an outcome of safety, permanency and well being of the child/family.

Who can attend the meeting?

Parents are an essential part of any child and Family Team Meeting. They can invite anyone they feel will be supportive to them. It is also important to include children who are old enough to participate.

What happens at the meeting?

A trained facilitator will lead a discussion that will be directed at the goals established by the child and/or family. The primary purpose for each Child and Family Team Meeting is to make meaningful and thoughtful decisions about a child and their birth family to help the family plan for the future.

What rights do families have at Child and Family Team Meetings?

- To be treated respectfully.
- To be able to choose support people to attend the meeting with the family.
- To be able to express feelings honestly and openly without fear of negative consequences.
- To play a primary role in the plan that is developed for the birth family.

How often are Child and Family Team Meetings held?

Some Child and Family Team Meetings are held during the first contact with the biological parent. Other meetings are conducted whenever a plan has to be made or an important decision is needed for a child involved with DCS.

You as a foster parent play a very important role in this process. You will be invited to a team meeting to assist the birth family and other team members to determine what is best for the child and family unless the parent asks that you not be included. At the meeting, it is essential that all team members identify strengths and needs the child and birth family may have and this is entered on a Case Plan. This Case Plan is what steers the birth family into addressing the needs/well-being objectives of the child and birth family.

Your Role in the Case Plan

The Case Plan is based on a partnership with the family and others. You as the foster parent will be included to encourage, assist, and mentor the birth family so that the safety, care and relationship with their child can be accomplished. The success of a child's reunification is not always the sole responsibility of the birth parent. The willingness of the foster parent to be involved in the Child and Family Team Meetings can be a great determining factor in promoting supportive relationships.

Common Foster Parent Responsibilities

It may often times be requested of you to allow visitations in your home either supervised or unsupervised so that the time that the biological parent is spending with their child is as positive and reassuring as possible. Other types of activities you could be involved with regarding the Child and Family Team Meetings is:

- Providing transportation
- Assisting the child in sending cards and pictures to their parents
- Working together with the biological parent and child on a Life Book
- Attending court proceedings
- Recording information regarding the child's medical/developmental activities
- Help to prepare your foster child for visits
- Share with biological parents information and skills that are relevant to providing a safe home for the child
- Maintain confidentiality
- Recognize when the biological parent needs assistance

Supportive Expectations

You should expect to receive support from your DCS worker regarding your involvement in the Child and Family Team Meetings. As you can imagine, an open relationship between you, the DCS worker, and the birth parent help all four—you, the worker, the birth parent, and the child. It is important to share information with the worker. You can also ask questions of the process.

It is good to remember that nobody has all the right answers all the time. You should feel comfortable sharing the good times as well as the times when little progress seems to have been made. Your worker may want to visit with the child alone. Such visits can add to your mutual understanding of the child.

The worker is the link between the child and the birth family. A good relationship between worker and child can enable them to talk about the situation, and can help the child have a better understanding of the reasons for placement with a foster family. Good communication is vital in the successful healthy placement of the child. The child's feeling of well-being is often dependent upon the free flow of information between the worker and foster parents. In order to best help your foster child, remember to ask and remember to share.

The results of using this team meeting can be, but are not limited to, the following:

- Increased use of kinship/relative care and placement with siblings
- Reduced length of stay and number of placement moves
- Increased reunification and adoption rate
- Reduced use of substitute, institutional, and group care
- Improved outcomes for children and families

Understanding Court Hearings

- **Detention Hearing—**A detention hearing shall be held no later than 48 hours of involuntary removal of the child from the home. After hearing testimony from all involved parties, the judge will determine if removal was in the best interest of the child and if the child should continue in an out-of-home placement. Foster parents usually do not attend the detention hearing unless they are called to testify as to the condition of the child.
- **Initial Hearing—**At this hearing, the petition alleging that the child is a Child in Need of Services is presented to the judge. The judge will read the specific allegations/charges to the parent/guardian of the child and ask if they admit or deny that the facts of the petition are true and that the child is in need of services.
- **Fact Finding Hearing—**If the parent/guardian denies that the child is a Child in Need of Services, this hearing is held so that the judge may hear arguments from both DCS and the parent/guardian. Following testimony, the judge will make a decision as to whether the child is a Child in Need of Services or is safe to return to/continue in the parent's care. Foster parents will usually not be a part of this hearing unless they are called to testify as to the condition of the child.
- **Dispositional Hearing—**If the child is found to be a Child in Need of Services, this hearing will be held and DCS will present recommendations for continued placement of the child and for services needed by the child and family. Foster parents may attend this hearing and may make recommendations concerning services for the child.
- **Dispositional Modification Hearing—**If new information arises or there is a significant change in the child's circumstances or placement, this hearing may be held in order that the DCS present evidence of a need for modification of the dispositional decree. Foster parents may attend this hearing and may make recommendations concerning services for the child. These matters may be addressed in a Periodic Review hearing.
- **Periodic Review Hearing—**At a minimum of every 180 days from the date of the child's removal from the home or as often as needed, this hearing is held in order that the judge can review the progress of the case, compliance of the parents with services ordered, and the need for continued placement of the child. Foster parents are to be notified prior to this hearing, are to be a part of the hearing, and may make recommendations concerning the child.
- **Permanency Planning Hearing—**This hearing must occur within 360 days of the child's removal and at least every 360 days thereafter until permanency is achieved. Foster parents are to be notified of this hearing, are to attend, and may make recommendations concerning the child.
- **Rule to Show Cause Hearing (Contempt Hearing)—**This special hearing may be held when DCS has evidence to present to the judge that the parents are failing to follow court orders concerning a matter such as services, support, or visitation, or this evidence may be presented at a Period Review Hearing. Foster parents usually will not attend this special hearing unless they are called to present testimony.

Note:
Courts will vary as to whether or not the child is expected to attend any or all hearing and your child's FCM will be sure that you have clear instructions. Generally, a child who is old enough to understand his circumstance will be asked to attend for at least a part of a Periodic Review Hearing, since the focus of those hearings is on the child's progress. As a foster parent, you can help your foster child to prepare for attending a hearing by assuring him/her that you will be there for support.

See updated *Child Welfare Policies, Chapter 6: Court, ,* ***http://www.in.gov/dcs/2535.htm***
See *Manual, Chapter 3, Children in Need of Services*

Court/Legal Terminology

- **CHINS (Child in Need of Services)**—A child who has been abused or neglected by a parent/guardian/custodian and on whose behalf the intervention of the court is needed to assure his/her continued safety.
- **Parent**—A person who is either the birth or adoptive parent of the child.
- **Guardian**—A person appointed by a court to be the caregiver of a child.
- **Custodian**—A person with whom the child resides or any person responsible for the child's welfare who is employed by a public or private residential school or foster care facility.
- **Perpetrator (PERP)**—The person who has abused or neglected a child.
- **CASA (Court Appointed Special Advocate)**—A Court Appointed Special Advocate is a volunteer who is considered an officer of the court for the purpose of representing the child's interests. A CASA may be appointed by the judge at any time during a CHINS hearing and will want to become very familiar with the child, perhaps talking with you as the foster parent and visiting the child in the foster home. CASA is a participant in the case planning for the child and will speak up for the best interests of the child in court hearings.
- **GAL (Guardian Ad Litem)**—A Guardian Ad Litem, like the CASA, is considered an officer of the court for the purpose of representing the child's interests and will want to become familiar with the child. Unlike a CASA, a GAL will focus on protecting the child's legal interests and will speak for the child in court hearings.
- **Magistrate**—An appointee who with the appointed/elected Judge shares the responsibility of hearing CHINS cases.
- **Case Plan**—A form documenting input of all appropriate parties as to the services to be provided/completed in order to bring about reunification.
- **Reunification**—The child's return to the legal parents or guardian.
- **TPR (Termination of Parental Rights)**—Severing the parents' rights to the child in order that the child may be adopted.
- **PPP (Parent Participation Plan)**—A document similar to the case plan but focused on the parents' responsibilities as ordered by the judge.
- **Family Court**—Not operative in all counties, a Family Court judge may preside over not only Juvenile court matters (CHINS and probation) but also over other matters which impact families, such as divorce and guardianship.
- **Bailiff**—The Bailiff is an officer of the court who maintains the schedule, announces the hearing, calls for specific witnesses, takes participants into and out of the courtroom. He/she may be responsible for keeping order in the waiting area and inside the courtroom, or a law enforcement officer may also perform that function.
- **310**—The form completed to document a report of abuse or neglect.
- **311**—The form completed to document the investigation of an abuse/neglect allegation.

Pointers for Foster Parents Attending a Court Hearing

Be on time; however, although you will be given a specific time at which to appear for a hearing, the hearing may not occur at that time. It is difficult for court sessions to remain on schedule because of the seriousness of each hearing. One hearing may be very short, while another may go on well past the allotted time. Bring something to read in case your hearing is delayed. If you were instructed to bring the foster child, bring something to help occupy his/her time in quiet activity.

Ask your child's FCM ahead of time what the hearing will be like. Juvenile courts are structured differently around the state and may range from informal—with all participants, including the judge, sitting around a table and talking—to very formal, with the judge presiding from the bench and multiple attorneys and other court personnel present.

Be prepared to go through a metal detector at the courthouse entrance. Minimize wearing any metal objects such as jewelry or a belt buckle (since you may have to take these off) or carrying anything metal in your pockets or purse, and under no circumstance have anything that is or could be used as a weapon.

Dress appropriately and see that the foster child is dressed appropriately. A courtroom is a place of serious business. Dress the same as you would if attending church—no shorts or revealing clothing, no t-shirts with inappropriate messages written across the front, no torn jeans, etc.

Do not chew gum or eat inside the courtroom.

Look to the bailiff (court officer) to guide you into the courtroom at the appropriate time and indicate where you are to sit.

Do not speak until you are spoken to by the judge or an attorney. If you wish to speak, raise your hand. You may be asked to come to the front of the room and sit in the witness stand, or you may be asked to present your information from your seat. It is a good idea to stand while speaking if you are at your seat in a courtroom of any size.

Be courteous (and this certainly applies to your older foster child). Address the judge as "Sir/Madam" or "Your Honor".

Make notes beforehand and bring them with you if you have information to present. This will help you to be clear and concise. Assure your foster child that if he/she wishes to speak, the judge will listen, but do not coach the child in any way.

Leave when you are dismissed. The judge may not choose to have the child stay for the full hearing and you may be asked to go with the child to the waiting area until the end of the hearing if the child is too young to wait on his/her own; or you may be dismissed and free to leave.

Remain calm and quiet. The judge may ask the bailiff to escort you or your foster child out of the courtroom or may find you in contempt if you become upset or angry.

Guidance for Foster Parents who are Subpoenaed to Testify in a Trial

If you receive a subpoena to testify in a trial, do not bring the foster child unless the child is also subpoenaed. The atmosphere in the courtroom may be very different from what you experience in other hearings. Often there will be a request for "separation of witnesses" and in that case, you will not be able to sit in the courtroom during the testimony of other witnesses. Further, in the waiting area you must not to talk to other witnesses or participants about the case or about their/your testimony. The bailiff will admit you to the courtroom when it is time for you to testify and direct you where to be seated -- usually beside the judge in the witness box.

The attorney representing the DCS will question you first and he/she may first ask you to identify yourself. Speak clearly and loudly enough to be heard. You may also be asked to state your credentials—if you have completed foster parent training; if you have a license as a foster home; and how long you have been a foster parent. Do not be embarrassed to say that you are new at foster parenting!

Do not take notes or other papers with you to the witness stand unless you have first shown them to the DCS attorney and he/she has agreed that you may take them. While notes or documents may be helpful to you, the opposing attorney will ask you what you have in your hand, will want to see them, and will question why you have them.

Answer all questions truthfully but answer only what you are asked. Keep your answer as short as possible. Your foster child's FCM will have talked with you ahead of time as to what information will be valuable for you to present and he/she will have gone over this with the DCS attorney. If you have other valuable information to present, the DCS attorney will no doubt ask you another question that will allow you to present this.

Try to be as specific as possible. For instance if the question to you is "Does the parent ever miss visits with the child?" A good way to reply would be "Yes, mother missed 3 of the 4 visits last month", instead of "Yes, she misses a lot of visits."

Remain calm. The opposing attorney may ask you to repeat something you have already said and may even seem to be questioning your truthfulness. He/she may ask you to be more specific or may imply that you should know an answer. For instance, "Do you know why mother missed those 3 visits?" Your best answer to such a question is a simple "No". The FCM will answer those questions when he/she testifies. Never argue, or state your opinion.

When there are no more questions for you, the judge will dismiss you. The bailiff will show you out of the room and he/she will tell you if you are free to leave (sometimes a witness may be recalled to testify to some further question that comes up).

Being a Foster Family

DCS Terminology to Know

- **Family Case Manager (FCM)—**The person assigned to work with your foster child and his/her family. The FCM will schedule frequent regular visits with you and the foster child in your home and will visit more often at critical times (following placement, during a crisis, or when reunification is contemplated) or when needed. Call the FCM when you need information about the child, or when you have questions or concerns about the child.
- **Foster Care Case Manager—**The person assigned to work with you as a foster parent. He/she may be part of the pre-service training team and will complete the initial assessment of your home to secure your license. The Foster Care Case Manager will see that you are aware of in-service trainings and will track the training hours you complete. The Foster Care Case Manager will visit you at least annually to update your progress in meeting the requirements of fostering and at the appropriate time will complete the necessary work for your re-licensing. He/she is the person to contact if you have questions about your license, about training, or about DCS policies related to foster parenting.
- **Foster Care Licensing Specialist—**An employee of a private social services agency or a private individual contracted to fulfill the role of the foster care case manager. He/she will visit with you on the same schedule as the DCS Foster Care Case Manager would and can provide information as needed.
- **Pre-service Training—**Initial training required as part of the preparation process to become a foster parent.
- **In-service Training—**On-going training required to maintain a foster care license.
- **Licensed Child Placing Agency (LCPA)—**A private social services agency licensed by the State of Indiana to maintain a foster home program with its own trained and licensed foster parents. DCS is often unable to meet the need for foster homes, especially for special needs children, large family groups, or teens, and frequently makes referrals for the use of LCPA homes. LCPA foster families may attend your pre-service or in-service training and may be a part of your support group if one is active in your county.
- **Indiana Child Welfare Information System (ICWIS)—**The computer system used by DCS to track activities related to the children and families with whom they have contact.
- **Life Book—**This is a scrapbook full of memories to help the child document the important occurrences in his/her life.
- **Respite Care—**Short-term placement of a foster child to provide the foster parents relief from intensive care giving. Please talk to your child's FCM or your foster care FCM to learn how respite care is managed in your county.

Foster Parent Training

Pre-service, First Aid, adult, infant and child CPR, and Universal Precautions training are required for anyone wishing to become a foster parent. Once licensed, annual on-going training is required. The type of license that is held by the foster parent will determine the amount of training that is required. Information regarding specific training requirements may be obtained from your foster care case manager, training coordinator, or the Child Welfare Policy Manual. It can also be located at ***http://www.in.gov/dcs/2527.htm (Chapter 12, Section 5)***

There are three types of foster care licenses: Traditional, Special Needs, and Therapeutic. Traditional foster homes are licensed through the local DCS. Special needs foster homes may be licensed through the local DCS or a Licensed Child Placing Agency (LCPA). Special needs foster homes provide care for children who have a physical, mental, or emotional disability and as a result require additional supervision or assistance. Therapeutic foster homes are licensed through a LCPA and provide care to children who may be seriously emotionally disturbed or developmentally disabled to the point where many services are required. All three types of homes may accept traditional placements. Special needs and therapeutic homes may accept special needs placements, but only therapeutic homes may accept therapeutic placements. The per diem is based upon the child's condition and not the type of license that is held. See the Indiana statute at: ***www.in.gov/dcs/2533.htm (Chapter 8, Section 3)***

If an individual holds an active foster home license with an LCPA and requests to transfer the license to the County DCS, in-service training must be current prior to the transfer.

If an individual was previously licensed as a foster care provider but relinquished the license in good standing, in-service training would be required to re-activate a license. If it has been more than four years since the license was relinquished, pre-service training would be required to activate the new license. See policy on License Reinstatement at: ***http://www.in.gov/dcs/2527.htm (Chapter 12, Section 28)***

In-service training to fulfill the required hours may be acquired from a variety of sources. Procedures are established for earning in-service training credit from other training available in the community, specialized medical or behavioral training, or the review of approved books and videos. Contact your local training coordinator or Foster Care Case Manager to learn more about these options. See policy on In-Service Training at:
http://www.in.gov/dcs/2527.htm (Chapter 12, Section 14)

See updated *Child Welfare Policies, Chapter 12: Foster Family Home Licensing*
See *Manual, Chapter 6: Licensing*

Before Saying Yes

As you consider taking a child into your home for placement, review your own skills and abilities to accommodate the needs of the child. Consider the information you are given and determine if you can safely parent the child to avoid even further disruption in the child's life. Remember to keep all information you are given confidential.

Information to Have/Questions to ask **Prior to** Placement

1. What is the child's name, gender, age, and ethnicity?
2. Is this an emergency placement or is the child coming from another foster home?
3. Why is this child in care/coming into care - abuse/sexual abuse, neglect, other reasons?
4. Does the child have special medical needs, a physical disability, or an emotional impairment?
5. Does the child have any special behavioral challenges or habits—acts out sexually, wets himself/herself, plays with fire? Has the child harmed others or shown cruelty to pets? Does the child have any fears, or fears related to abuse (bath, bedtime, animals, etc.)? Does the child sleepwalk or night-roam?
6. What services will be put in place to support the placement.
7. What is the long-term plan—return to the parents soon, placed with relatives, stay in care long term, adopted?
8. Does the child understand the reason for placement? What explanation was given to the child?
9. Is there an immediate appointment, court hearing, visitation, or other activity that we need to prepare for?
10. Does this child have appointments or other activity regularly scheduled that will require more than routine transportation?
11. What grade is the child in and what school does the child attend? Will we be enrolling him in our neighborhood school? If the child is young, does the child have an approved day-care provider?
12. Does the child have a pet that also needs a foster home?
13. Discuss with FCM prior to having child's haircut, dyed to get parental permission.

Information to Have/Questions to ask **at the Time of** Placement

1. Child's date of birth (and birth certificate if needed to enroll the child in school)
2. What are the discipline instructions for this child?
3. May the child telephone family members, friends, or significant others today and on a regular basis? What are their names?
4. What are the visitation arrangements (Visitation plan, if written; otherwise, visit location, who will transport and who will supervise?)
5. Does the child attend church and will he/she want to continue attending there? Is that a good plan since the parents may attend also and have access to the child?
6. Does the child participate in other activities that should be maintained (Scouts, music lessons, YMCA/YWCA, etc.)?
7. When is the next court hearing? Will I receive a notice? Should I bring the child?
8. Does the child have a Court Appointed Special Advocate (CASA) or a Guardian Ad Litem (GAL)?
9. Child's Medicaid card
10. Names and addresses of the child's doctor, dentist, eye doctor, and approximate dates of last appointments, if known
11. Where should I take the child in a medical emergency?
12. What is the provision for clothing if the child's current supply is inadequate?
13. What do you know about the child's habits? (Eating: What food does the child like? Any food allergies? Sleeping: When does the child usually go to bed? Are they a light/ heavy sleeper? Bed-wetter? Sleep-walker? Night terrors?)
14. What are the restrictions of an older child? Does the child smoke (understanding that the child/teen should not be smoking but is good information to know)? Have a boyfriend? Date alone? Go out in groups? Hang out at the mall? Have a cell phone? Use birth control?
15. Contact information for the FCM
14. After-hours contact information or emergency procedure (for instance, what do we do if the child runs away?)

Emergency Placements

Many times children must be removed from their homes in emergency situations often in the middle of the night, on a week-end, or even on a holiday. Once you are licensed, talk with your licensing case manager about what it is like to accept a child on an emergency basis. He/she may describe a situation of an infant found truly abandoned or a child whose parents are hospitalized or jailed. In these situations, little or nothing may be known about the child other than a need of a safe place to go for the night. In other situations, the FCM may describe a child removed from a home where living conditions are filthy or hazardous or where drugs are being manufactured. He/she may have more immediate information about this child but you may be cautioned to check for head lice or watch for roaches in the child's clothing (if the child can bring any clothing at all), or you may need to give the child a thorough bathing to see that he/she is free of any drug residue. Probably the most difficult situation the FCM may describe is the child who will come to you bruised or battered. The FCM may or may not have immediate information about this child, depending on whether the parent is cooperative or is angry and refuses to communicate; but the emotional impact is often difficult.

Let your licensing FCM know if you decide that your family can accept an emergency placement or if you are more comfortable with placement of a child about whom more immediate information is available.

See updated Child Welfare Policies, Chapter 8, Section 9: Placing a Child in Out of Home Care
http://www.in.gov/dcs/2533.htm

See Manual, Chapter 4, Children in Care

Knowing When to Say "No"

Always remember **YOU HAVE THE RIGHT TO SAY "NO"** if you feel a child will not fit into your family, if you believe you cannot cope with a child's problem as described, or if you need a break from fostering. Saying "no" will not result in you not being contacted for other placements. If you do accept a child for placement in your home, make a commitment to care for the child as long as possible. Moving from home to home is not healthy for a child and can be emotionally damaging.

Impact of Fostering on the Foster Family[2]

You must take care of the needs of your own children just as you would take care of the needs of a foster child. For the biological or adopted child in your family the arrival of a foster child can be just as difficult as the impact of the birth of another child, or even more.

The foster child often arrives without the preparation that surrounds the birth of a sibling. The phone call, your decision, and the arrival of the child can all occur within a few hours. The foster child may be close in age (actual or developmental) to your own child, and strong competition and rivalry can emerge.

Children in foster care have special needs and often demand extra attention, which your own children may resent. These feelings may be hard to put into words, and are often mixed with feelings of guilt. ("I'm not happy about sharing my toys, but I know I should share.") It is important to be alert to possible feelings of resentment by your children.

The entire family needs to incorporate the foster child into family activities to enable the foster child to feel cared for and secure. At the same time, you need to make an effort to have special time with the family and individual time with each of your biological or adoptive children. Some families take short "time-outs" between foster care placements in their home to come together again as a family.

You may also find yourself worrying about the behavior of the foster child and the influence of the behavior on your children, especially if they are young or impressionable. On the other hand, your children can serve as excellent role models and may become more sensitive to others' backgrounds and experiences.

You can help with some of the feelings your children might have about the foster children in their home. Allow your children to express feelings about foster care that sometimes might not be positive. Encourage communication and avoid quick responses or judgments that might shut down communication.

Empathize with your children the difficulty of having other children come into their home and into their space, and assure them that it is okay to be frustrated and angry sometimes about being a foster family and having to share home, family, and personal belongings with someone else.

The Adjustment Period

Children entering foster care go through a grieving process that includes stages of shock or denial, anger and despair before arriving at a stage of acceptance or at least understanding of why they are in care. Separation from birth parents is difficult for all children, regardless of the reason for placement. Children often show their emotional reactions to previous abuse and neglect and to separation from their families through their behaviors.

Following is a description of the stages of the grieving process and typical behaviors a child may exhibit at each stage. The length of the grieving process varies for each child; and, in fact, the process differs for each child. Some children may not appear to go through some of the stages at all; others may go through a later stage first, for instance may immediately be very angry or very sad (despair); and others may stay in one stage for a very long time but pass through other stages quickly. While most children will reach acceptance within six months, some will adjust more quickly and others will take much longer.

Stages of Grief and Loss

Shock or Denial (Honeymoon): Feelings repressed

- Emotions may be absent, shallow or somber
- May appear to be withdrawn or sleep a lot
- May over-eat or refuse food
- May deny that anything has happened
- May seem confused

- May be a model child
- May regress and suck thumb or wet the bed

Anger: Feelings expressed

- Realizes implications of living with new family
- May break things, throw temper tantrums, scream, cry, set fires, steal, lie, act out sexually, or run away
- May be aggressive or disruptive at home or school
- May be anxious, tense, and hyperactive
- May refuse to talk with or about birth parents
- May direct thoughts and behaviors toward the lost person
- May feel they themselves are to blame for the placement

Despair: Feelings directed inward/sadness

- Accepts reality of placement and that returning to family may not occur soon
- May be depressed, withdrawn
- Doesn't want to interact with others, few demands made
- May feel disorganized, restless
- May be preoccupied with things rather than people
- May regress to an earlier time in life when things were happier
- May have physical complaints, stomach aches
- May injure self

Acceptance

- Feels and acts secure in environment
- Seeks new activities and begins making emotional investments

Some Hints to Smooth the Road

Following are suggestions to help the child through the grieving stage.

Shock and Denial

- Receive the child quietly. The child is already self-conscious, frightened, and confused. Avoid extra social demands. Settle down to a regular routine as quickly as possible and have any welcoming celebrations later.
- Respect the child's feelings for the past. Do not probe. Let the child know that the door is open if the child wants to talk and that you accept the fact that the past has been different.

- Respect the child's parents and the child's loyalty to them. The child's own parents are important.
- Support visits with the parents.
- Let the child have prized possessions and provide a place to keep them.
- Allow time.
- Focus on the child's good behavior. While it may be easier to focus on and punish wrong behavior, it is often more helpful to reward the child's good behavior. (It is important to point out the things the child does well and what you like about the child, as well as what you want the child to learn or change. A child in foster care may doubt your positive remarks initially, but if you are sincere and persistent, the child will begin to believe you and to develop a better self-image.)
- Avoid threats. Warnings of "I'll tell your worker" or "I'll send you back home" leave painful impressions. This sets the worker up as the "bad guy" and heightens the child's sense of vulnerability. Over time, this undermines the child's sense of security and is destructive to the child.
- All family members should focus on helping the child feel more comfortable.
- Use household tasks constructively. Give the child responsibilities in line with age—not too many, not too few. Give the child recognition for carrying them out. Appropriate household responsibilities increase the child's sense of belonging.
- Help the child accept strengths and limitations and don't push beyond the child's capacity.

Anger

- Give messages to the child that it is okay and normal to be angry.
- Show acceptable ways to work out the anger—running, talking, punching bags, drawing, etc.
- Help the child to understand that he is not to blame for the placement.
- If the child tells exaggerated stories, do not pump, ridicule, or argue; determine with the child's worker what is real.
- Allow time.

Despair

- Encourage the child to talk about feelings.
- Ask how the child feels but do not probe.
- Dolls and pictures may help young children act out feelings through play.
- Older children should be supported and helped to express hurts and worries.
- Get the child interested in and helping with a life book.
- Show respect for feelings and provide hugs and appropriate affection.

Acceptance

- Provide the child with new interests and opportunities to develop new relationships.
- Allow the child to remember and talk about times both current and past with the birth family.
- Continue to work with the child on the life book.[3]

"One father is more than a hundred schoolmasters."

—George Herber

Helping the Child Understand Your Family Routines[4]

The everyday routines of your family may take place without much thought or discussion. All families have patterns of behavior and living together that work for them. Your home may have a schedule that you regularly follow, or it may vary and be quite flexible. Before a foster child enters your home, your family should sit down together to discuss what you feel is important, what a new person needs to know to become a part of the family.

The kind of routine a child brings to your family will depend on where and with whom the child has been living. Some children may come to your family from another foster family or group home where there may have been many rules and a planned daily schedule. Other children may come to you from families where there were few rules and no set schedule.

Most children will need some time alone to become comfortable with their space. They will need time to watch the family's routine before they can be active participants. Think about some of your family's routines that might take a child some time to learn. For example, who usually gets up first, and who usually goes to bed last? Is there someone who gets to use the bathroom first? Do children get snacks after school? Can anyone help themselves to things in the refrigerator or cabinet?

Even going to sleep and waking up can be very scary times for children just placed in foster care, and many foster parents have developed routines to help children go to sleep and wake up. There are good reasons for bedtime stories and night-lights. It is also important to give children permission to get up and use the bathroom.

There is a fine line between a family's routines and rules. Routines may be such things as an understanding that everyone sits down together for meals, who sits where at the table, or foster dad gets the recliner in the TV room. Rules are important to help maintain health and safety such as staying with a parent at a grocery store. Be prepared to help your foster child become oriented to your family routines and rules in the easiest way possible.

Family Names

A child in foster care should maintain his/her legal surname and should not use the foster family's surname. Foster care is temporary and the use of a foster family's surname by a child implies a more permanent situation to the child and the birth family. If a child placed in your home wishes to use your surname, discuss this with the child's case manager.

As to given names and titles, it is important that foster parents address the child by the name with which the child is comfortable, such as a nickname instead of an actual first or middle name, and the child's case manager will be able to help you with this. Because a foster child entering your home may be unsure of what to call you, it is important for you to give the foster child some options and give permission to refer to you in the way that is most comfortable for the child.

For example the foster child may call you by your first name; by Aunt or Uncle; by Mr. and Mrs., etc. Some foster children may reserve the titles of "mom" and "dad" for their birth parents but others may ask permission to call you "mom" and "dad" to honor your role in the foster home. If you are uncomfortable with this, it is okay to give the child some alternative suggestions.

Life Books

A Life Book is a visual record of a child's life and those who have shared it with them. It is a collection of memories, history, documents, and souvenirs. When a foster parent takes the time to assist the child in creating their Life Book they are enhancing their relationship with the child and helping the child to understand and be connected to their past. They are also providing a tool that will allow the child to share their history with others including their birth family members or their adoptive family.

Three main things to remember when creating a Life Book:

- This is an ongoing and not a time-limited process. Do not set a due date to complete this project as it is an ongoing account of the child's life.
- Due to the sensitive nature of the information being gathered, creating the Life Book must be done at the child's pace; the child is in charge unless the child is very young then the foster parent may lead the process.
- The foster parent is not a therapist but they must be sensitive to the child's needs as the book is created. If professional assistance is needed to continue the process, seek help through the child's case manager.

Those involved in creating a Life Book may be:

- The child
- The foster parents
- The adoptive parents
- The biological family members - important to include when able
- The child's therapist (especially when working towards permanency)

Life Book Construction Tools:

Life Books can be created in many ways. Some families choose to start with a pre-written Life Book they obtain through the County Department of Child Services, American Foster Care Resources, or other sources. Some families choose to start with a 3-ring binder that they add pages and plastic sleeves, while others choose to purchase a photo album or memory book. Crayons, markers, pens, colored paper, stickers, etc, should be available to make the book special to the child creating it.

Information gathered before starting a Life Book includes:

- Information about the child's birth family
- Important documents such as a birth certificate
- Information about the child's removal from the biological family
- A list of previous placements
- Names of previous case managers
- Names of schools attended, favorite teachers
- Religious information
- Developmental milestones (Child's firsts)
- Medical information
- Photographs of birth family, foster families, friends, etc.

Places to gather this information prior to starting a Life Book:

- The child
- The child's Case Manager
- The birth family (parents and extended family members)
- The school (their yearbook photographer)
- The church (youth director for photos & info)
- The medical passport

Things to include in a Life Book:

- Photos of families, friends, homes (labeled and dated)
- School awards
- Important papers/documents
- Stories and poems written by the child
- Letters from birth family members, foster parents, etc.
- Ticket stubs and programs from special events
- Other important mementoes and documents

Ways to help when the child cannot remember their past or information is not available:

- Allow the child to "relive" some experiences that would have been normal for the lost time-period. For example, take an adolescent to the circus and allow them to act as if they were seven. Allow a seven-year old to ride a tricycle. Take photos as they do these things and include them in the life book.
- Have the children make up a story about what they think may have happened during a certain time period. For example, list "This is what_____thinks happened when he was _____years old." This will allow the information to be updated later when the facts are learned.
- Have the child cut pictures from magazines or draw pictures when photos are not available.
- Take the child on a trip to the "old neighborhood", school, etc., and take photos. Have the child write about it.

The role of the foster parents in the Life Book process:

- Be available to work on the book
- Gather information prior to starting the book
- Purchase the materials for making the book (let the child help choose)
- Purchase a nice box for the items too big for the book
- Be sensitive to the child's needs as the book is created
- Recognize when issues need further attention
- Photograph the child's "space" and special places such as their bedroom, foster home, school, church, etc. Make notes regarding daily events on a calendar. Allow the child to also make notes on the calendar, and then include these in the Life Book.
- Have a loaded camera ready to catch memorable moments.

Let us get Creative—Ways to make a Life Book special:

- Write a letter recalling the child's first day in your home. Allow the child to write a letter about that first day if he is old enough to remember it.
- Write a letter to the child as his placement with you is ending. Let them know how you feel about them and their new life. Let the child know you will be available if they need you later in life.
- Have the child write a journal regarding their private thoughts and remind them to date their entries. This journal should not be read by anyone without the child's permission.
- Make a vacation or special event collage.
- Create special memories. Do not just wait for them to happen.

Family Life Books

Foster parents are encouraged to create their own family life book that can be shared with each child who enters into their home. This is an excellent way for foster children to become familiar with the home and those who reside there. At a minimum, photos of each room, the members of the household and family pets should be included in this book.

Cultural Considerations

www.in.gov/dcs/2533.htm (Chapter 8, Section 2)

A child's race and ethnicity are an important part of the child's identity. It is vital that you respect a child's race and cultural identity because respect contributes to the development of a positive self-image for the child. If the child is of a different race than your family, it is encouraged that you find ways to help the child maintain activities and connections that are familiar. This will demonstrate your acceptance of the child and convey your care and concern. Some ways of doing this might be to:

- Attend community events for the child's ethnic group,
- Listen to music that is a part of the culture, or
- Prepare foods that are common in the child's biological home.

You will find that you may need to become more familiar with holidays or traditions that are a part of the foster child's ethnicity so you can be more sensitive to these needs. In addition, children of different races or ethnicity may require special considerations regarding skin and hair care. If you are unfamiliar with these differences, consult with the child's case manager for additional resources.

Religious Practices/Church Attendance

Foster children have the right to opportunities for religious and spiritual development in accordance with their religious preference and that of their parents. The foster child's parents should be involved in decisions about the child's participation in the practice of your religion. This includes attendance at church, educational classes, and special events such as baptism. The child should not be required to participate in religious training or observances contrary to the religious beliefs of the child or the wishes of the child's family. You may invite the child to attend religious services in which you participate, but the child should not be required to attend. If the child chooses not to attend, it may be necessary for you to arrange for supervision of the child during that period of time. Placement decisions may also include efforts to match the child's religious needs with the foster parents' ability to meet that need. You should discuss the child's religious training with the child's case manager before accepting a placement.

Parenting Cross-Culturally

Often times when a child is removed from the child's own family, culture, ethnic background, or community and then is placed with a family of a different culture, ethnic environment, and/or community, several outcomes may be predicted:

1. Very important elements of support for self-concept, self-esteem, self-identity and self-confidence may be removed.

2. Without consistent and on-going contact with their family, culture, ethnic background, and/or community, children may lose contact with their family traditions, culture, ethnic background and/or community. These ties help them maintain bonding with their family, friends, and community. As a result, the children may be unable to integrate their family's relationships, culture, traditions, values, ethnicity, and coping skills successfully.
3. Foster children may feel devalued if their culture, traditions, religion, ethnicity, and community is ignored, degraded, or rejected.
4. The children may feel inadequate if they are forced to take on different cultural, traditional, and ethnic identities.
5. Most importantly, children may believe and feel that their family's life, way of doing things, and community are being destroyed for a new family's life, way of doing things, and community.

With an understanding of the importance of culture to the mental and social development of foster children, we must also recognize that all cultures and communities have undesirable elements, as well as desirable ones. The ability to identify proudly with the best in your own culture/community and reject the worst is a guide to the development of a successful individual or society. The ability to help foster children make positive choices and develop into productive adults requires an accurate knowledge of the children's family, culture, ethnic background, and community.

All families, cultures, ethnic backgrounds, and communities have some things in common, some differences, and some factors that affect some individuals of each group, but not all individuals of either group. To know and understand a family, culture, ethnic background, and community other than your own, requires serious work and a very open mind.

In order to meet the needs of foster or adoptive children, foster parents should give careful thought to the following:

Family

1. The foster parent's extended family's relationship with the child placed in the home and the type of relationship that can be expected;
2. The foster family's and the community's perceptions and reactions to the social, ethnic, and cultural group to which the child belongs, and how to encourage positive interaction between the two;
3. Traditions, values, norms, and child-rearing practices of the foster family and their suitability for parenting a child of a different culture and ethnic background;
4. The foster family's and community's strengths, boundaries, roles, rules, acceptance or rejection of the child and their family, and how to help the child and their family to understand and to respond to both the foster family and their community;
5. The strengths of the child's family, cultural, ethnic and racial group, and how to help the child maintain bonding with their family and friends; and
6. The child's choice of music, dance, hairstyle, dress, etc.

Building Self-Concept

1. Promote, encourage, and support the child's attachments and connections to their legal family, extended family, friends, community, religion, church, racial, cultural, and ethnic groups;
2. Reinforce the child's and their legal family's strengths;
3. Screen negative racial, cultural and ethnic information, and inter-actions/reactions; help the child to screen and adjust to them as well. When a child of a diverse group is placed in a home, the foster parent is encouraged to contact a person of the child's culture and ethnic background to help the child understand prejudice and racism, and help the foster parent and the child develop coping strategies for developing and/or maintaining a positive self-concept.

Communication

1. Teach the child his or her culture and history.
2. Identify the child's cultural and ethnic needs and communicate those needs to the family case manager and community.
3. Communicate openly the foster family's wishes relative to meeting the child's cultural and ethnic needs to the community, and the DCS

Note: Racial jokes or slurs should never be permitted in the presence of foster children. If that occurs, the child **SHALL BE** supported immediately by the foster parent or the adult who is present.

Food

1. When foster children are placed in a foster home, most likely they will have already acquired a taste for various ethnic foods. Usually, children from diverse groups eat a wide range of the same foods, but the preparation, flavor, and smell may be different. A concerted effort should be made to make the children's favorite food a part of their daily diet.

Helpful Aids

Foster parents play a very important role in the lives of foster children. They play a major role in promoting and encouraging positive self-concept and identity. Foster parents are to select books with culturally diverse people in them because foster children need to see others who look like themselves in positive roles doing positive things.

The foster parents have a responsibility to familiarize themselves with literature and magazines that are representative and responsive to families and children of diverse groups.

Foster children need to be exposed to pictures, posters, books, and people who portray members of the child's family in a positive way. Ethnic toys, games, movies, and dolls are to be made available, and the children are to be encouraged to play with and accept them.

Note: It is very important that members of the foster care team be committed to learning and understanding each other's culture and ethnic backgrounds, as well as the culture and ethnic backgrounds of children placed in their care.

See updated *Child Welfare Policies, Chapter 8, Section 1: Consideration of Race, Color or National Origin During Placement (IEPA),* ***http://www.in.gov/dcs/2533.htm***

See *Manual, Chapter 4, Children in Care*

Letting Go/Contact after Removal

When the placement ends, foster families are expected not only to assist the child in attaching to the permanent caretakers, but also to detach from the child and "let go." It is important for foster parents to receive support during and after the separation. While workers and foster parents are busy helping the child cope with feelings and the anticipated move, the foster parents' own feelings sometimes take a back seat. It is important for the foster parents to take time during this process to examine their own feelings about assisting the child in developing a healthy and strong attachment to the new caretakers.

If the placement in your family disrupts and the child must be placed with another foster family, you may feel guilty. Foster parents need to realize that some placements simply do not work well for a particular child. Open communication is needed between the foster family and case manager. It is helpful to share thoughts and evaluate "what went wrong and what went right," and to discuss some of the bad feelings about the placement.

No matter where a child goes after leaving the foster home, foster parents can give valuable insights and information about the child to the next caretakers. While the child has been in your home, you will have been working with the placing agency and other professionals and the family to correct the conditions that led to placement or to secure an alternative permanent placement for the child. Even so, you may have ambivalent feelings about the child returning home or going to another family. Have the birth parents really changed? Is the child going back to the same conditions the child left? Is the child ready for a new family? It is important for you to recognize and deal with these issues during the separation process. By understanding yourself, you can better understand and help the child through the separation. In decisions about the return or moving of the child, consider the best interests of the child. Not everyone will agree with every decision made, but the final decision rests with the court. After the foster child leaves, you may need time to evaluate your own experience and make some decision on future placements.

If you know ahead of time that a child will be moving from your home, you may want to talk to the child's case manager about your level of involvement with the child after the child leaves. You will want to discuss how this could happen or whether it should happen, as contact after removal may not always be in the child's best interest. If the child is going into a more intensive or more restrictive level of care, you may be encouraged to remain in contact in order for the child to return to your home after the need for that placement ends. Whatever the case, you will need to let your wishes be known and negotiate this with the child's case manager.

Finding it Hard to Say Goodbye

Children entering foster care grieve for the loss of their parents and the familiar surroundings of home and family. This is also true for foster parents who grieve for the foster children to whom they have given so much love and care and who return to their own families or to move on to other foster or adoptive homes. It is very important for foster parents to understand and accept that the feelings they experience at these times are normal, and that by giving themselves permission to grieve they can come through the process with renewed energy and dedication to fostering.

Obstacles to the Healthy Resolution of Grief[5]

There are many barriers in our society and in our personalities to expressing grief fully. There are four important areas that make it very difficult for people to grieve, and foster parents are at risk in all of these.

Ambivalent Relationship

1. First, grieving is often difficult when the relationship to the lost person was ambivalent or hostile. Foster children are often troubled, which makes for strained relationships. There may be a good deal of relief when they leave, especially because of the acting out which so frequently is part of the child's separation anxiety. There may also be relief of no longer having to have contact with a biological parent who was troublesome. Many people, foster parents included, disparage the value of what was lost in order to defend against the pain of grief. An example of this is, "Why should I miss him? He really never fit in here anyway; he caused so many problems and wasn't happy here."
   "I'll leave him before he leaves me" is another attempt to avoid emotional pain. Many times a foster parent will ask to have a child removed a couple of weeks or days before the child is supposed to move to an adoptive home or return to a biological parent. There are times when the child's behavior becomes extraordinarily difficult to handle, but more often, the grief of impending loss is so great, in both foster parent and child, that the foster parent asks for an earlier replacement to defend against the pain. However, the loss is no less painful because one has had a part in bringing it about. In fact, the pain may even be increased.
   Additionally, foster parents represent the child's past and thus are frequently avoided or even disparaged by those biological parents and adoptive parents who cannot tolerate the child's links to, and feelings about, his past. This can only increase the foster parents' pain at a time when they are most vulnerable, and make them wonder about the value of their work.

Demanding Role

2. Important real life demands that make it extremely difficult, if not impossible, for the bereaved to grieve constitutes a second complication. Foster parents usually have several other children, foster and biological, in their home, and the demands of childcare and homemaking often offer little opportunity for the expression of grief. In addition, with the scarcity of foster homes, a social worker will often put in a new child as soon as the other child leaves, or sometimes even before, in anticipation of a vacancy. It is most important that the bereaved be discouraged from making critical decisions because of the danger of creating secondary losses at such a vulnerable time. For example, the decision to take in another child or to drop out of the foster parent program should not be made right after a foster child has left.

Social Expectations

3. The third important factor is whether there are social supports for grieving. Often the expectation is held by the placement agency, the biological parents, adoptive parents, and even other foster parents that foster parents are not supposed to get too attached, and that somehow deep sorrow and grief on losing a foster child is "neurotic"" and a sign that all is not well in the foster parents' understanding of their role. In addition, it is much more

difficult if the foster parents decide after the child leaves that they would have wanted to adopt the child (or knew before but the agency did not agree that this would be in the child's best interests), or if the child is going into a situation about which the foster parents have grave concern.

Personality

4. The fourth barrier to grieving is a personality based on avoiding feelings of loss and dependency and the need to always appear independent and competent. If this is the situation, then expressing grief may be regarded as a sign of weakness and thus grief is inhibited. Our society values the ability to cope and carry on, and many bereaved persons become very absorbed in everyday activities, only delaying the grief process. Foster mothers are accustomed to being nurturers and taking care of needy children; feeling dependent and helpless for a time may be very difficult for them.

Grieving, in some degree, accompanies all change and growth. From a growth perspective, it is often through the modification of goals and expectations that a person comes through these changes and losses with renewed interest and zest. A negative outlook causes an individual to remain fixated on the past and old losses. This type of outlook can hinder the healing process for many foster parents. For example, a foster parent can look only at fixed outcomes, (the child is gone; he went to a family I do not like and who does not like me) or they can look at a growth process, (the child was with me for three years and I gave him a great deal during that time. I did my best in preparing him for the move, and that nurturing will always be part of him).

Support

Foster parents accept the challenges and demands of parenting along with the enormous commitment and energies required of them. Often times foster parents need to care for themselves as well as caring for the foster children. Below are some ways foster parents can meet their own needs and prevent excessive stress or burnout: (Melcher 1985)

1. At the point of entry, foster parents with the assistance of the family case manager, can explore and understand the difference between involvement and excessive commitment. The former leads to satisfaction and effectiveness, while the latter leads to burnout.
2. Foster parents can develop outside support systems and be involved in satisfying activities that are separate and distinct from foster care.
3. Foster parents can take time off periodically, through the utilization of respite care with another licensed foster parent (formally provided by the Department or informally arranged by the foster parent with the permission of the Department).
4. Group interaction and support are particularly important. Participation in foster parent support groups is a valuable intervention.
5. Foster parents can share both their pleasant and difficult experiences with one another because talking about it reduces isolation and may prevent burnout.
6. Foster parents can have every opportunity to participate actively in the foster care system, both in relation to decision-making about a particular child and in the development of policy and procedures that will affect their services in child welfare.

Special Issues with Relative/Kinship Care

www.in.gov/dcs/files/cwmanual4.pdf (The Placement Process)

Many children across the state who need to be removed from their homes are placed in the homes of relatives; grandparents, aunts, uncles, cousins, or adult siblings who care for relative children who would otherwise be in foster care. Relative care not only allows the children to live with someone they love and trust, but also provides protection and security, maintains the children's cultural identity, sustains family connections, and allows the children to continue to build healthy relationships within the family.

While relative care is the best alternative for children who cannot live with their own parents, relative caregivers in certain circumstances may face challenges that foster parents do not. They may need help and support from the child's FCM, the foster care licensing worker, or in some cases, even the judge in resolving these challenges.

Your role changes dramatically when you become the caregiver for your relative child. In the past, the child may have had a good time visiting in your home, perhaps playing with his/her cousins and even spending the night occasionally. However, now that you are in the parent role, you will be:

- Establishing his daily routines, which may be far different from what he is accustomed to: dinner together at the table, homework before play, early bedtime on school nights, dirty clothes in the hamper, church on Sunday, etc.
- Providing guidance and discipline: good table manners, no hitting or shouting, share your games and toys, go to time out, and respect adults.
- Limiting contact with his parents to the level that allows him to maintain that relationship but also to be safe.

After a possible "honeymoon" period, your relative child may be very angry about this new arrangement. Some common behaviors could be that of verbally or physically striking out, trying to run away, being openly defiant, or destroying property. If your relative child appears very quiet and keeping to himself/herself, appearing sad or depressed, having difficulty sleeping or eating, be sure to contact your FCM for help.

These behaviors are not different from behaviors that many foster parents see in children placed in their care. The difference may be the role change between you and child's parents. Depending on the circumstances, you may now have to limit the time the parents spend in your home and thereby having access to the child. It may be very difficult for you to say these words to someone you love, especially knowing it will limit your own contact with them. You may experience an initial anger or resentment from the child's parents. Other family members may even blame you for "taking the child away from his/her parents". Other relatives may be hurt that the child had not been placed with them. The entire family may be divided over these issues.

It is very important that you have all of the information surrounding the circumstances of the relative child's case. It is especially important that you attend court proceedings in order to hear first hand the orders given by the judge that will affect you and the child. It is a good plan to request the FMC meet with both you and the parents in order to establish how the court orders will be carried out, assuring that both you and the parent hear the same instructions at

the same time, taking the burden off of you. The FCM will be able to help when problems arise and, if necessary, they can request that a court proceeding be set if problems persist, especially if the child's safety is threatened.

If you choose to become fully licensed to care for your relative child all information in this guide applies to you as well as to foster caregivers. Relative and foster caregivers should be aware that before the child has been in care for twelve months, the FCM must formulate a permanency plan for the child. "Permanency" is a term used by DCS to mean a permanent living arrangement for the child; one where the child will grow up without DCS supervision. DCS should not remain in a child's life for any longer than necessary to resolve the issues that brought the child into care initially. If those issues cannot be resolved within a reasonable length of time, then DCS must move to establish permanency for the child by another means.

The FCM must write a permanency plan for the child and present it to the court by the time the child has been care for 12 months. If the plan is accepted by the court, the FCM must work to see that the plan is carried out as soon as possible when it is in the best interest of the child. Below are some of the options that may be considered by the court for permanency for children in relative care:

- **Reunification—**returning the child to the parents
  This is always the first choice of DCS when the safety and well-being of the child can be assured. Reunification of the family can occur when the judge agrees that the parents have met the goals set out in their case plan; for instance, completion of substance abuse treatment.

- **Adoption—**terminating the legal rights of the birth parent and granting full parental status to another
  This is the preferred plan for any child who cannot be reunified with his/her own parents. Many relative caregivers choose to adopt their grandchildren, nieces, nephews, or other relative children in order to give them a permanent home and maintain family relationships. For most children, adoption subsidies in the form of continued financial assistance is available to the adopting family. The FCM can give you information regarding this issue.

- **Guardianship—**establishing a legal relationship between the relative caregiver and the child
  This relationship allows the relative/guardian to act on the child's behalf without the supervision of the DCS. A guardianship order does not grant legal rights as fully as an adoption decree, but it is permanent unless/until a further court order is issued. In some instances, an Assisted Guardianship is available meaning that continued financial assistance is available to the guardianship family. The FCM can give you information regarding this issue.

- **Other planned permanent living arrangement—**Continuing the child under CHINS and DCS supervision
  This type of arrangement can occur when none of the above plans is appropriate for the child. Often this plan is best for an older child who is finishing high school and is working toward independent living.

Should you choose to make a permanent commitment to your relative child those emotions experienced within the family at the beginning of placement may resurface and need attention again. As in the beginning, your child's FCM will be a resource in helping you to work through these issues.

The following are some other resources that may be of assistance to you as a relative caregiver.

AARP's Grandparent Information Center
www.aarp.org/families/grandparents/gic/a2004-01-16-grandparentsinfocenter.html

Child Welfare League of America
www.cwla.org

Children's Defense Fund
http://www.childrensdefense.org/site/PageServer?gclid=CKi5lMT0uJYCFSEeDQod0lwiLw

National Center on Grandparents and Other Relatives Raising Children
http://chhs.gsu.edu/nationalcenter

Grandparents Caregiver Law Center
http://www.seniorlawcenter.org/legalissues/li03.shtml

Grandparents Raising Grandchildren
http://www.usa.gov/Topics/Grandparents.shtml

Through the Eyes of a Child—Grandparents Raising Grandchildren series
www.uwex.edu/relationships/

National Indiana Child Welfare Association
www.nicwa.org

Frequently Asked Questions about Kinship Care (Child Welfare League of America)
www.cwla.org/programs/kinship

Grandparents Raising Grandchildren
http://www.cwla.org/programs/Kinship/2005statefactsheets/indiana.pdf

Kinship Care Resource Guide
www.parentsagain.com/KinshipManual.pdf

Support Groups

A support group may help to address emotional needs, especially in times of stress specifically related to foster care. A support group may enable foster parents to build relationships and companionships. They can provide training, education, advice, and supportive information that might not be available otherwise. A support group can also identify problems that are not limited to an individual situation and can suggest approaches to problem solving. Local support groups may be available by county or region.

Foster Parent Associations

Indiana Foster Care & Adoption Association, Inc. (IFCAA)

IFCAA is a statewide non-profit organization of legal parents, foster/adoptive parents, and other caring professionals who work together for the well-being of foster and adoptive families. IFCAA conducts state and regional conferences for state accredited training to foster/adoptive parents and other professionals. The association works to encourage communication and understanding of the foster care and adoption systems between care providers. As a service to foster and adoptive families, the association maintains a toll free number to the office for assistance with problems or questions. Local foster care and adoption support groups are encouraged to utilize IFCAA resources. This includes access to speakers and assistance in the organization of new support groups. IFCAA also publishes a quarterly newsletter for information updates to members. The association promotes recognition of achievement with awards to foster/adoptive parents and scholarships to students. Through the IFCAA network of members, state and national legislative issues that impact foster care and adoption are both monitored and pursued.

Contact Information

Indiana Foster Care and Adoption Association, Inc.
509 East National Avenue
Indianapolis, IN. 46227
Phone: (317) 524-2600, Toll-free: 1-888-252-3678
Website: ***www.ifcaa.org***

The National Foster Parent Association, Inc. (NFPA)

NFPA offers the opportunity for information sharing, problem solving, and research relative to all aspects of foster parenting. A bi-monthly publication providing information, opportunities for higher educational pursuits for foster and birth children, participation in national training conferences, and access of many services and materials are available to all members. For membership information, call 1-800-557-5238 or visit their website, ***http://nfpainc.org/.***

For information on other Indiana support groups available, contact the Indiana Foster Care and Adoption Association at (317) 524-2600 or Toll-free: 1-888-252-3678.

Confidentiality

Confidentiality of Information

www.in.gov/dcs/files/cwmanual4.pdf (Section 403.165, page 17)

Foster parents must be very careful not to discuss specific information concerning their foster children with extended family members, friends, neighbors, medical providers (when the reason for the visits do not relate to abuse or neglect of the child), school personnel, day care staff, and even other foster parents. All information regarding children in foster care and their families is confidential. Indiana Code (IC 31-33-18-2) authorizes DCS to release confidential information to foster parents as the persons providing care to the child, but foster parents are required to honor that same level of confidentiality. Likewise, Indiana Code (IC 5-14-3-10) establishes that there are penalties for unauthorized disclosure.

Confidential information regarding the child will be shared with the foster parents when:

- It is necessary for the safety of the child and /or the foster family;
- It is in the child's best interests;
- It can help the foster family to decide whether to accept a child into the family It can help the foster family better understand the child's behavior; and,
- It can help find solutions to problems throughout the placement.

The FCM's responsibility in information sharing is to assure that the foster parents receive the following:

- Basic reasons for placement;
- Any known physical or mental disabilities;
- Basic health needs;

- Specific information about behavior problems;
- Life experiences that may affect the child's behavior and about which the child may wish to talk;
- Information about the child's family; and,
- The strengths of the child and the child's family.

The foster parents' responsibility in information sharing includes:

- Using the confidential information only to promote and achieve the health, safety, and best interest of the child;
- Helping the child understand that information about them may be shared between foster parents and case managers; and,
- Sharing with the family case manager critical information the child discloses.

Foster parents have the right to expect that the information they disclose about themselves, during the initial assessment process or thereafter, will be treated with the same level of confidentiality as is information concerning the foster children. However, foster parents must be aware that some information regarding their work as foster parents is public record.

See updated *Child Welfare Policies, Chapter 2 (Section 7); Administration of Child Welfare, Confidential Information,* ***http://www.in.gov/dcs/2539.htm***

See *Manual, Chapter 11, Case Management and Administration*

Household Issues

Crib Safety

Consumer Product Safety Alert

From The U.S. Consumer Product Safety Commission, Washington, D.C. 20207

Safe Sleeping for Babies

- Always place babies on their backs to sleep, for naps and at night. The back sleep position is the safest.
- Place babies on a firm sleep surface, such as on a safety-approved crib mattress, covered by a fitted sheet. Never place babies to sleep on pillows, quilts, sheepskins or other soft surfaces.
- Keep soft objects and toys, and loose bedding, out of babies' sleep area. Don't use pillows, blankets, quilts, sheepskins or pillow like crib bumpers in their sleep area, and keep any other items away from the baby's face.
- Keep babies' sleep area close to, but separate from, where you and others sleep. Your baby should not sleep in a bed or on a couch or armchair with adults or other children, but he or she can sleep in the same room as you. If you bring the baby into bed with you to breast-feed, put him or her back in a separate sleep area, such as a bassinet, crib, cradle or bedside co-sleeper (an infant bed that attaches to an adult bed) when finished.
- Think about using a clean, dry pacifier when placing the infant down to sleep, but don't force the baby to take it. (If you are breast-feeding your baby, wait until your child is 1 month old or is used to breast-feeding before using a pacifier.)
- Do not let your baby overheat during sleep. Dress your baby in light sleep clothing, and keep the room at a temperature that is comfortable for an adult.
- Reduce the chance that flat spots will develop on your baby's head by providing "tummy time" when your baby is awake and someone is watching, changing the direction that your baby lies in the crib from one week to the next, and avoiding too much time in car seats, carriers and bouncers.

Sources: *National Institute of Child Health and Human Development, National Institutes of Health, U.S. Department of Health and Human Service*

SIDS:

www.insids.org/

www.cpsc.gov/CPSCPUB/PREREL/PRHTML96/96096.html

www.cpsc.gov/CPSCPUB/PUBS/softsleep.pdf

Cribs free of cost at
Marion County Cribs for Kids (317) 536-2769
www.insids.org/resources.php

Shaken Infant Syndrome[6]

Shaken Infant Syndrome is a severe form of head injury caused by violently shaking an infant or child, usually when the infant is crying inconsolably and the frustrated caregiver loses control. The violent shaking may result in severe injuries to the infant, permanent brain damage, or death. Severe damage of this type is common in very young infants, but it can happen to even three and four year olds.

Shaken baby syndrome can occur from as little as five seconds of shaking. Young infants have weak neck muscles and only gradually develop the strength to control their heavy heads. If shaken, their heads wobble rapidly back and forth, which may cause brain damage and bleeding in and on the surface of the brain. Injuries are most likely to happen when there is both acceleration (from shaking) and deceleration (from the head hitting something). Even hitting a soft object, such as a mattress or pillow, may be enough to injure newborns and small infants.

Some play activities are hazardous too, such as:

- Repeated, vigorous tossing of a small child into the air;
- Jogging while carrying an infant on the back or shoulders;
- "Riding a horse" (child faces the adult while sitting on his swinging foot or bouncing on the knee);
- "Cracking the Whip," while swinging the child around by the ankles; and
- Spinning a child

The following tips for preventing Shaken Infant Syndrome are the advice of several leading pediatricians knowledgeable in this field:

- The most important rule to remember is to **NEVER SHAKE AN INFANT** under the age of two (2) for any reason.
- Always provide support for the baby's head when holding, playing with or transporting the child. Instruct others who care for the infant in the proper support of the head.
- Make sure that all those who are in contact with the infant know the dangers of shaking. This includes babysitters, child-care personnel, even siblings or foster siblings who may accidentally injure the infant in rough play if not properly instructed.
- Learn what to do if the baby will not stop crying. All babies cry a lot during the first few months of their lives.
- **Learn what to do if you shake the baby, either accidentally or on purpose:** Even though you may feel embarrassed or guilty, it is imperative that you get the baby to the emergency room immediately. Bleeding inside the brain can be treated but only if you tell the doctors the baby has been shaken.

[6] In. Chapter of the National Committee for Prevention of Child Abuse. Adapted from Southern Nevada Chapter NCPCA

Guns/ Fire Arms

If fire arms are kept in the home or on the property of a foster family, fire arms and ammunition are to be stored in two separate locked places which are not accessible to children.

Water Safety

Water is everywhere in and around a home. While some water safety practices are common sense, some may not be.

Safety practices for within the home include:

- Keeping your water heater at an appropriate temperature
- Not leaving liquids laying around unattended (such as a cleaning bucket) as it takes only a small amount of water for a baby or toddler to drown,
- Never leave a small child in the bathroom or bathtub alone.

Safety practices for around the home include:

- Having a pool safety plan
- Never allow an easy access to a pool, pond, lake, etc.
- Utilizing safety locks on all doors providing access to water
- Installing a high fence around pools
- Never leaving children unattended near water
- Utilizing life jackets when on a water craft or fishing from the ground
- Having children participate in swimming and water safety lessons
- Having adults in the home be trained in water safety and rescue.

Smoking

Foster parents have the right to disallow smoking in their home, and given the known health risks, they should strongly discourage foster children from starting or continuing smoking.

Foster parents should not purchase tobacco products for any foster child, as it is illegal in Indiana for children under 18 to purchase cigarettes. If foster children are in possession of tobacco products, please talk to the FCM about this as soon as possible.

Foster parents who smoke should do so in an area where foster children are not subject to second-hand smoke. Secondhand smoke is a mixture of the smoke given off by the burning end of a cigarette, pipe or cigar and the smoke exhaled from the lungs of smokers. Secondhand smoke contains more than 250 chemicals known to be toxic or cancer causing, including formaldehyde, benzene, vinyl chloride, arsenic, ammonia, and hydrogen cyanide.

If an adult must smoke inside, there should be a limit to rooms where windows can be opened or fans can be used and away from the immediate living area. Smoking should never be allowed in the foster child's sleeping areas. Any vehicle used to transport children must be smoke-free.

Alcohol

Foster parents have the right to allow alcohol usage in their own home, but serious consideration should be given to the usage of alcohol in the presence of foster children. Because of the exposure many foster children have had to alcohol and the negative effects of their care takers using it, trauma can be caused by their being subjected to others using it in the foster home.

Foster parents should not purchase alcohol for any foster child, and it is illegal in Indiana for children under age 21 to purchase it. If a foster child is found to be in possession of alcohol, a meeting should be held with the FCM as soon as possible.

All pets are to have rabies vaccination. Proof of up-to-date vaccination is provided to the licensing worker and a record is to be kept on file in the home.

Medication Safety

The administration of medicine to foster children is an important task. When obtaining medications for a foster child request written instructions for administering and then follow those instructions completely. It is requested that the foster parent keep a medication log of when the medicine has been administered. Foster parents do not have the discretion to adjust medications or doses. A physician must make any changes of the dosage amount. If a foster child has an adverse reaction to a prescribed medication, seek treatment immediately.

Foster parents who take medications on a regular basis should be careful to take it as instructed and should use caution in storing the medicine. All prescription and non-prescription medications should be stored out of the reach of children and, whenever possible, they should be secured with safety seal caps. An additional medication safety issue is the growing number of teenage children who are stealing prescription drugs, using them to get high and/or selling them at school to other students. It is good to be aware of and monitor the medication that is in your home.

When a foster child exits a foster home, any medicines and instructions for dispensing it should be given to the case manager to deliver to the new care taker. Information regarding the child's health issues and history should also be provided via the Medical Passport.

Matches/lighter Safety

Safe storage of matches and lighters should be considered for your foster home. Children of any age should be safe guarded from access to both matches and lighters by securing any of these items out of their reach and possibly considered storing them in a locked container. It is recommended to safeguard your family and home as there are children who have fire fascinations.

Household Chores and Responsibilities

Children in foster care may be given family responsibilities consistent with their ages and abilities. Successful completion of specific tasks can help to build the child's self-esteem and self-confidence but you will need to consider the child's past experiences when assigning a task or giving a responsibility since the child may need instruction.

For example, a child who has never lived on a farm may lack the knowledge and judgment in safely accomplishing a task specific to farm life. In some cases, the assignment of chores may be part of a more general behavioral management plan for the child. In these situations, you should discuss this matter with the child's case manager.

Car Seats and Safety Belts

http://www.aap.org/family/carseatguide.htm

Under current Indiana code (IC 9-19-11), all children under 8 years of age must be restrained in a child passenger restraint system which meets the current Federal Safety Standards when riding in a motor vehicle, unless the child will not fit in such a system.

Additionally, all children between the ages of 8 and 16 years of age must be properly restrained by a safety seat belt. The driver of the car shall be guilty of a Class D infraction in the event of non-compliance with any part of this law.

Important Information to Remember

- If a car seat has been involved in an automobile accident, it should be replaced.
- Car seats should never be purchased from a garage sale as you would not know if it had ever been involved in an automobile accident.
- Car seats have a limited span of effectiveness and may need to be replaced before children have outgrown them.
- Improperly installed car seats and those not fitted properly for the child who will be using it, could be ineffective and unsafe. Contact your local hospital to inquire about safety seat inspection sites near you. Be sure to take both the child and the seat with you to your appointment.
- Children learn by example—Use your seat belts and they will use theirs.

On the following page is a chart outlining general information regarding the use of child seats:

General Child Seat Use Information

	Age/Weight	Seat Type/ Seat Position	Usage Tips
Infants	Birth to at least 1 year and at least 20 pounds	Infant-only Seat/rear-facing or convertible seat used rear-facing **Seats should be secured to the vehicle by the safety belts or by the LATCH SYSTEM**	• Never use in a front seat where an air bag is present • Tightly install child seat in rear seat, facing the rear • Child seat should recline at approximately a 45 Degree angle • Harness straps/slots at or below shoulder level (lower set of slots for most convertible child safety seats) • Harness straps snug on child; harness clip at armpit level
Infants	Less than 1 year/20–35 pounds.	Convertible seat/used rear-facing (select one recommended for heavier infants)	• Never use in a front seat where an air bag is present • Tightly install child seat in rear seat, facing the rear • Child seat should recline at approximately a 45 Degree angle • Harness straps/slots at or below shoulder level (lower set of slots for most convertible child safety seats) • Harness straps snug on child; harness clip at armpit level
Preschoolers/ Toddlers	1 to 4 years/at least 20 pounds to approximately 40 pounds	Convertible Seat/forward-facing or forward-facing only or high back booster/ harness **Seats should be secured to the vehicle by the safety belts or by the LATCH SYSTEM**	• Tightly install child seat in rear seat, facing forward • Harness straps/slots at or below shoulder level (lower set of slots for most convertible child safety seats) • Harness straps/slots at or above child's shoulders (usually top set of slots for convertible child safety seats) • Harness straps snug on child; harness clip at armpit level
Young Children	4 to at least 8 years, unless they are 4' 9" (57") tall	Belt-Positioning Booster (no back, only) or high Back Belt-Positioning Booster **Never use with lap-only belts** **Belt positioning boosters are always used with lap AND shoulder belts**	• Booster used with adult lap and shoulder belt in rear seat • Shoulder belt should rest snugly across chest, rests on shoulder; and should NEVER be placed under the arm or behind the back • Lap-belt should rest low, across the lap/upper thigh area—not across the stomach

Head Lice

Head Lice—A Common Occurrence[8]

Head lice infestation is very common and a challenge for children and parents worldwide. Preschool and elementary age children 3 to 10 years of age, can be infested most often, and females more often than males, perhaps due to more frequent head to head contact. In the US, African Americans are rarely infested with head lice, perhaps due to the shape and width of their characteristic hair shaft.

What are head lice?

The life cycle of the head louse has three stages: egg, nymph, and adult.

- Eggs: Nits are head lice eggs. They are hard to see and are often confused for dandruff or hair spray droplets. Nits are laid by the adult female and are cemented (which makes them difficult to remove!) at the base of the hair shaft near the scalp. Nits take about a week to hatch.
- Nymphs: The egg hatches to release a nymph. The nit shell then becomes a more visible dull yellow and remains attached to the hair shaft. The nymph looks like an adult head louse but is about the size of a pinhead. Nymphs become adults in about 7 days.
- Adults: The adult louse is about the size of a sesame seed and is light in color (but will appear darker in persons with dark hair). Adult lice can live up to 30 days on a person's head. To live, adult lice need to feed on blood several times daily and without blood from the host, will live only 1 to 2 days.

How do I know if my child has them?

The majority of the time there are no symptoms. When symptoms occur, they may include a tickling feeling of something moving in the hair, itching caused by an allergic reaction to louse saliva, or irritability. Secondary bacterial infection may be a complication.

How does my child get them?

The main mode of transmission is to have contact with a person who is currently infested (i.e., head-to-head contact). Contact is common during play activities like sports, playgrounds, at camp, slumber parties, at school and at home. Less commonly, transmission may occur from wearing clothing such as hats, scarves, coats, sports uniforms, or hair ribbons worn by an infested person; also by using infested combs, brushes or towels; or by lying on a bed, couch, pillow, carpet, or stuffed animal that has recently been in contact with an infested person.

How do I treat them?

Treating head lice is a 3-step process:

1. **Kill all the live lice.**
   Treat everyone in the family who is infested. Over the counter treatments are available as

are prescription medications. Always contact your family case manager first because many offices can have supplies available, as do many schools and county health departments. Read and follow directions carefully because all these products are insecticides and must be used with caution. Some products can be toxic to children younger than age 2.

2. **Check for and remove all the nits** (a special nit comb is very helpful). Be patient, work in good light, and use the nit comb supplied with many of the products. You may need to do this several times.

3. **Clean the environment.** Head lice do not survive long if they fall off a person and cannot feed. You do not need to spend a lot of time or money on house cleaning activities. Follow these steps to help avoid re-infestation by lice that have recently fallen off the hair or crawled onto clothing or furniture:

   - Machine wash (hot water and high dryer heat) or dry clean all clothing and bed linens that the infested person came in contact with during the 2 days before treatment; or, store all clothing, stuffed animals, comforters, etc., that cannot be washed or dry cleaned into a plastic bag; seal the bag for 2 weeks.
   - Soak combs and brushes for 1 hour in rubbing alcohol, Lysol(c) or wash with soap and very hot water.
   - Vacuum the floor and furniture. The risk of re-infestation from a louse that has fallen onto a carpet or sofa is very small. Do not use fumigant sprays; they are not necessary and can be toxic if inhaled or absorbed through the skin.
   - Do not worry about your pet. Head lice do not live on pets.
   - Prevent re-infestation by teaching your children how head lice is transmitted and helping them to avoid such circumstances.

When can my child go back to school?

Check with your child's school because policies vary, but most schools have a "no-nit" policy to control outbreaks. When you have completed the three steps listed above, it should be safe to send your child back to school as long as you continue to treat and check for nits over a 3-week period. (One missed nit can re-infest your entire household!).

For help, check out the Center for Disease Control website given in the footnote on the previous page, or ***www.headlice.org***, or call 1-888-542-3646, the National Pediculosis Association. It is very helpful to call an experienced foster parent for support and reassurance during this challenging time also.

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[1] *U. S. Department of Health and Human Services Centers for Disease Control and Prevention:* ***http://www.cdc.gov/lice/head/treatment.html***

Available Financial Resources

Financial Terminology You Should Know

- **Per Diem—**The amount given as reimbursement for each day you care for the child.
- **IV-E/FC Reimbursement—**This is a specific payment from a fund where a large portion of the per diem is paid. It is important that DCS use this fund whenever possible and you can help by not allowing your foster care license to lapse for any reason. ***http://www.in.gov/dcs/files/5.5_Alleged_Fathers.pdf***
- **Payment in arrears—**Payments for a child's care that has not been paid to you yet. A per diem will be paid to you at the beginning of each month for the number of days the child was in care with you the previous month. If payments are in arrears, you will be paid for the day a child comes to your home regardless of the time of day that he/she comes; but you will not be paid for the day the child leaves your home, again regardless of the time of day.
- **Clothing allowance—**The amount paid each year for clothing for the foster child in your care. In some DCS Offices, this may be a one-time allowance when the child first comes to your home. Other offices will allow clothing to be purchased as needed during the year. Please talk to your child's FCM or your licensing FCM about how your DCS Office manages this.
- **TANF (Temporary Assistance to Needy Families)—**This is a program managed by the Division of Family Resources to provide temporary financial assistance to a single parent family or a family in which a parent is disabled/unemployed/underemployed (unable to work, possibly due to illness, or lack of education or job training). Funds from this program are also available to qualifying relatives now caring for a child whose parent was previously eligible for this program.
- **Indiana Medicaid—**Indiana's program for providing medical care to individuals who are disabled; persons who receive TANF benefits, or children previously in a family eligible to receive those benefits who are now in relative or foster care.

DCS Financial Resources

Each local county office of the Department of Child Services is responsible for insuring that children in foster placements receive appropriate care and to have their needs met. All funding is money generated by taxes.

Use of these funds may vary from county to county but most common uses are for per diem payments to foster parents, initial clothing allowances, medical and dental care not provided through Medicaid, counseling, therapy, and other needed services. These are provided by the Department of Child Services whether the children are placed in foster homes licensed by that office or through a child placing agency. In addition, many offices and LCPA's provide liability insurance for foster parents, respite care, foster parent recognition, camp fees for foster children, and a variety of other opportunities throughout the year. Ask your child's family case manager for information specific to your local DCS office or LCPA.

See updated *Child Welfare Policies, Chapter 8, Section 19: Clothing and personal items,* ***http://www.in.gov/dcs/2533.htm***

Indiana Medicaid

With few exceptions, all children in foster care will be eligible for Indiana Medicaid that provides coverage for most routine and specialized medical care, dental care, eye care, medical therapies, hospitalization, and mental health services. Children who are not eligible for Medicaid would be those very few who have a very high income in their own right—income from an inheritance, a family trust or a social security survivor's benefit, for example. If the child's legal parents carry private insurance, those benefits will follow the child and are to be used first to meet the child's expenses. Your child's FCM can help you to understand your foster child's benefits. Please refer to ***http://www.in.gov/fssa/dfr/2918.htm*** for more information.

WIC Program

Foster parents who care for infants and children up to age 5 are eligible to participate in the Women, Infant and Children (WIC) program when the foster children are Medicaid eligible.

WIC is a supplemental food and nutrition program and participants receive vouchers that are redeemed for specified nutritious foods at designated groceries. Such foods consist of baby formula, cereal, eggs, milk, peanut butter, juice and other foods to meet a child's specialized needs. WIC participants also receive nutrition education, nutrition counseling, and referral to other health services if needed.

- If you feel this program will be beneficial, look for the WIC office number in your local area, contact your family case manager or the following web site, ***www.fns.usda.gov/wic.***

Free or Reduced-Price School Lunches, Book Rental Fees and Book Fees

When you enroll a foster child in school or at the beginning of a school year, request an application for free or reduced-price school lunches, book rental fees or text book fees, as most all foster children qualify. A separate application is required for each foster child and each is considered a household of one. The income received for the foster child is requested and must be listed; this is the per diem received for the child only, not the foster family household income. Foster parents are not required to complete the blank requesting the social security number and will not have a food stamp or TANF number for the child, but must sign the application.

Foster parents making an application for their birth or adopted children will complete an application regarding their household members and personal income. The foster children and the per diem received should not be included in these applications.

Foster Parent Liability Insurance

Many DCS offices and Licensed Child Placing Agencies provide some level of foster parent liability insurance through the Indiana Foster Care and Adoption Association (IFCAA), but others are not able to budget for this expense. Please ask your licensing worker whether this is available to you. Foster parent insurance can provide liability coverage, for instance if as a foster parent you are sued by a birth parent or neighbor. It can also cover injury or damages caused by a foster child to you or your home as a supplement to your homeowners or renters insurance,

and to the person or property of someone else. It cannot cover any claims for the use, maintenance or ownership of a vehicle or watercraft. (In other words, if a foster child gets into your car and damages it or causes damage while driving, your auto insurance would cover such damage.)

If your local DCS office or LCPA does not provide coverage, it is available for purchase to members of the Indiana Foster Care and Adoption Association ***www.ifcaa.org***. Private companies can also write the equivalent of this coverage.

Taxes

Foster parents can contact the Indiana Department of Revenue Services for a copy of publication #501. There may be special considerations that foster parents should know about prior to filing their taxes and can be obtained at the following web sites:
www.irs.gov/publications/p501/ar02.html#d0e3180

Documentation

Good Documentation Practices!

As a foster parent, accurate documentation is vital because it enhances your effectiveness as a foster parent; increases your ability to advocate for the children placed into your care; and, it can protect you and your family.

Good documentation takes time and organization. When documenting, focus on the facts and avoid inserting your opinions. Confidentiality laws apply to documentation. Keep it in a secure location and do not share it with anyone other than professionals involved with the case. Consider sending periodic written reports to the case manager to keep them up to date on the progress of the case but call them with time or matter sensitive information. There are two main types of documentation: the child's information and the foster family's information.

Consider documenting these things regarding the child:

- Child's social history
- Any history of abuse or neglect
- Any history of making allegations against other foster families
- Child's medical, dental, & school information
- Child's behavior information
- Visitation notes and notes on all contacts with the child's family
- Clothing & personal belongings
- Incidents of injuries & illnesses (supplement with labeled, dated photos)
- Counseling appointments
- Fears, nightmares, bed-wetting, etc
- Birth family information

Documentation can take many forms such as:

- Written notes
- Email updates to the FCM
- Photographs (labeled and dated)
- Calendars
- Life Books
- Court Report Forms
- Legal Documents
- Medical Transcripts/Records
- Prescription Receipts

- Visitation Notes
- Report Cards/Completion Certificates/Progress Reports
- Clothing/Personal Belonging Inventories

Tools and forms used to document a child's information can include:

- Spiral Notebooks/ Log Books (For Daily Notes)
- Calendars - Regular and Baby Calendar
- Folders for Education/Medical/Legal Papers
- Case Plans
- Court Report Forms
- Medical Information Sheets
- Medical Passports
- Visitation Notes
- Clothing Inventory Forms
- Life Books

Tools and forms used to document a family's information can include:

- Log Book/Contact Book (for noting contacts with professionals involved with foster care and licensing)
- Photos/Incident Reports/Etc.
- Training Documentation (certificates, verification and credit forms)
- Binder or Folder for Documentation

Regardless of the documentation format that is chosen by a foster family, documentation is essential as it can ultimately affect the outcome of a case, which in turn affects a child's life.

Child Development

The Effects of Abuse/Neglect on Early Childhood Development[9]

By being more informed on the impact of abuse and neglect during early childhood development (birth to age 3), we will be able to take better care of these children and further understand why they have some of the emotional/physical problems they do.

Recent brain research suggests that warm and responsive care is not only comforting for an infant; it plays a vital role in healthy development. "Warm and responsive care" means meeting the baby's basic needs for food and shelter as well as responding to their moods and efforts to communicate. The care children receive at infancy directly affects the formation of neural pathways.

If a child experiences abuse or neglect during early childhood development, they will have difficulty later in life with such brain-mediated functions as empathy, attachment, and emotional expression. There are four developmental domains that can be affected by abuse and neglect:

Physical *(sensory and motor development)*,
Cognitive *(intellectual or mental development)*,
Social *(attachment and adoption of values)*, **and**
Emotional *(personal identification and self-esteem)*

Effects of Abuse/Neglect on Early Childhood Development:

- Absence of stimulation interferes with growth and development of the brain. Generalized cognitive delay or mental retardation can result.
- Malnutrition can interfere with healthy brain development, and in severe cases, may lead to mental retardation.
- Abused/neglected infants are often apathetic and listless, placid, or immobile. They are often inactive, lack curiosity, and do not explore their environments.

- They may fail to form attachments to primary caregivers, or show insecure attachment.
- They are often unresponsive to other people, may not maintain eye contact, may not become excited when talked to or approached, and often cannot be engaged into vocalizing (cooing, babbling) with an adult.
- Toddlers may not develop play skills and often cannot be engaged into reciprocal, interactive play.
- Abused/neglected toddlers typically exhibit language and speech delays. They fail to use language to communicate with others, and some do not talk at all.
- Abused/neglected toddlers may be fearful and anxious, or depressed and withdrawn. They may also become aggressive and hurt others.

Possible problems later in life from abuse/neglect during early childhood development:

- Violence/aggression
- Persisting state of fear
- Lack of attachment to others
- Inability to control emotions
- Hyperactivity (ADHD)
- Hyper-arousal
- Sleep disturbances
- Learning disabilities/mental retardation

Recommended Guidelines in Caring For Abused/Neglected Children

- Attend training on children abused during early childhood development.
- Be a consistent and trusting caregiver.
- Use gentle stimulation (hugs, belly rubs) for infants, but be careful to do this slowly, as they are easily overwhelmed or frightened.
- Expect progress, delays, set backs, and behaviors normally associated with a child younger than the one in care.
- Maintain counseling sessions on a regular schedule.
- Use clear and consistent communication in the home.
- Keep daily activities structured and consistent.
- Try to be as consistent as possible with rewards, discipline, and rules.

Child Development

Every child is born with a set of potential characteristics or traits. Some of these are shared by all of us and some of these traits come from genetic links inherited from birth parents and family. After a baby is born, development proceeds in stages. It is best for the child if the stages go in sequence. Each stage is important for the next one. For example, children crawl and pull themselves up on furniture before they begin to walk.

Children who have been abused or neglected very often have developmental delays and/or developmental disabilities as a result of the maltreatment. Sometimes these delays are significant. Abused or neglected children, on average, may be as much as two years behind in reaching their developmental milestones. Many continue to exhibit these delays even after the abuse or neglect has ended and their placements in foster care are stable.

Further, when we use the term "delayed", we should refer to the developmental trait and not to the child. Children usually develop at different rates on different developmental traits and milestones. Some children can be delayed in some areas and within normal limits in all others. The use of language is important in this regard. The use of the word "delayed" implies that the child still has the potential to grow and possibly even achieve normal limits, depending on what factors contributed to the delays. Therefore, we often divide delay into categories of mild, moderate, and severe to better represent the scope of a developmental delay."[10]

The next pages provide a quick guide to Common Characteristics of Children age Birth to 19.[11] If your child's development seems delayed, talk with your child's doctor or family case manager about getting help.

Birth to 19 Years of Age

Birth to Six Months

	Characteristics	Parents Should...
Physical	Develops own rhythm in feeding, urinating and bowel movements and in sleeping.	Adapt schedule to baby's rhythm as much as possible.
	Grows rapidly.	Supply adequate food. Change baby's position frequently. Exercise baby's arms and legs as you bathe and change him/her.
	Gains early control of eye movements.	Supply visual stimuli, such as mobiles.
	Develops motor control in orderly sequence.	
	Watch for these developmental milestones: ● Balances head ● Rolls over ● Pulls self to sitting position ● Sits alone momentarily	
	Begins to grasp objects.	Let baby grasp your fingers as you pull him/her up.
Mental	Learns through senses. Discriminates mother from others; is more responsive to her.	Provide objects to see, hear, grasp. Encourage shared play activities with child.
	Coos and vocalizes spontaneously.	Talk to him/her a lot
	Babbles in two word syllables.	
Social	Imitates movements. Gazes at faces. Smiles to be friendly	Play pat-a-cake and peek-a-boo.
	Likes to be played with, tickled and jostled.	Bounce him/her on your knee.
	Smiles at self in mirror.	Provide a mirror toy.
	Plays with hands and toes.	Allow freedom for hands and legs.
Emotional	Shows excitement through waving arms, kicking and wriggling.	Show facial expressions of smiling or frowning
	Shows pleasure with anticipation of bottle or being picked up.	
	Cries in different ways when cold, wet, hungry. Don't be afraid of spoiling him/her. A cry is a baby's main way of communicating needs.	Learn to "read" his/her cries.
	Fears loud or unexpected noise; strange objects, situations, or persons; sudden movement , pain.	

Six Months to One Year

	Characteristics	Parents Should...
Physical	Large muscle: 8 months on—crawls 9 months on may begin to walk	Be sure dangerous objects are out of reach. Provide experiences that give leg and arm exercise.
	Small muscle: Learns to let go with hands.	Know child will play "dropping things" game to help him/her understand the world.
	Puts everything in mouth.	Provide foods he/she can eat with hands and other activities which exercise fingers.
	Begins to have teeth appear.	Be especially patience; give child things to chew on. Child may be cranky
	Cannot control bowels.	Not try to potty train.
Mental	Learns through senses—especially mouth.	Provide toys and games that involve hearing, seeing, smelling, tasting and touching. Encourage shared play activities.
	Likes to put things in and take things out.	Be sure there are no toys with small or loose parts.
	Likes to do things over and over.	Repeat words and activities.
	Begins to understand such familiar words as "eat", "mama", bye-bye", "doggie".	
	Likes to hear you name objects.	Say the names of objects as the child sees or uses them.
Social	With adults: Finds mother or mother substitute extremely important.	Have one person be in charge of most of the child's care.
	Will "talk" using babbling sounds.	Talk to him/her a lot.
	Will start to imitate.	Do things you want the child to do.
	Has eating as a major source of social interaction.	
	With peers: Will not play with other infants—will poke, pull, push, etc., instead.	Not expect the child to play with others.
Emotional	Needs to be held and cuddled, warmth and love. Needs to feel sure someone will take care of him/her.	A special person should provide physical comfort. Needs of hunger, cleanliness, warmth, holding, sensory stimulation, and interaction with an adult should always be met. Don't be afraid of spoiling him/her.
	Becomes unhappy when mother leaves. Draws away from strangers. Same fears as before.	If mother must leave, a special person should provide care. Proceed slowly in introducing the child to new people.

One to Two Years

	Characteristics	Parents Should...
Physical	Large muscles: Begins to walk, creep up and down stairs, climb on furniture, etc.	Provide large, safe space for exercising arms and legs.
	Enjoys pushing and pulling toys.	Provide push or pull toys to help with balance in walking.
	Small muscle: Begins to feed self with a spoon and can hold cup.	Fix easily eaten food. Allow child to feed self at times.
		He/she will be messy.
	Can stack 2 or 3 blocks. Likes to take things apart. Likes to put in and take out things.	Provide toys or games he/she can take apart, stack, squeeze, pull, etc. Encourage shared play with the child.
	Takes off pull-on clothing	Let the child try to dress him or herself.
	Cannot control bowels	Not try to potty train.
Mental	Learns through senses.	Have toys or play games that make sounds, have different "feels", colors, shapes. Etc.
	Is curious— likes to explore—pokes fingers in holes.	Be sure play area is safe. Allow child to explore.
	Can say the names of some common objects.	Talk to child often. Say names of objects child see you use. Talk about activities during bathing and dressing.
	Uses one-word sentences – "no", "go", "down", "bye-bye". Can point to common body parts and familiar objects. Can understand simple directions such as "get your coat".	Teach names of body parts.
Social	With adults: Finds mother still very important	Have a special person provide most of the care.
	Enjoys interaction with familiar adults. Imitates—will copy your behavior.	Be sure to do the things you want the child to do.
	Demanding, assertive, independent, waves bye-bye.	Be patient.
	With peers: Plays alone, but does not play well with others the same age.	Although the child likes other children, he/she may want an adult close by.
Emotional	Needs the love, warmth and attention of a special adult to develop trust—the feeling that someone will take good care of him/her.	Have a special, caring adult look after the child.
	Personality traits: Reaches a peak of thumb sucking at 18 months.	Ignore thumb sucking. Calling attention to it will only make it worse.
	May throw temper tantrums.	Be patient.
	General emotion is "happy". Anger chiefly aroused by interference with physical activity. Cries because he/she cannot put wishes into words.	
Moral	Conscious of adult approval and disapproval.	Temper extreme responses to the child and respond consistently to various behaviors.

Two to Three Years

	Characteristics	Parents Should...
Physical	Large muscle: Runs, kicks, climbs, throws a ball, jumps, pulls, pushes, etc. Enjoys rough and tumble play.	Provide lots of room and many experiences in which the child uses arms and legs.
	Small muscle: Can turn some doorknobs, scribbles, eats easily with a spoon, helps dress and undress self. Can build a tower of 6 to 7 blocks.	Provide activities that use fingers—clay, finger paint, pick-up objects, stacking objects, large crayons for scribbling. Share in these activities with the child.
	Can begin to control bowels. Bladder control comes slightly later.	Gradually start toilet training. Consult an authority if unsure of methods.
Mental	Continues to learn through senses.	Provide sensory experiences.
	Still is very curious.	Allow child to explore. Have as few "no-no's" as possible.
	Has short attention span.	Not make child do things for more than a few minutes.
	Language: Uses 3 to 4 word sentences.	Talk to the child a lot. Explain simple things.
	Begins to enjoy simple songs and rhythms.	Sing songs that have repetition, are short and low in key.
Social	With adults: Considers mother still very important.	Allow time to do things for self. Allow time to explore.
	Does not like strangers. Imitates. Dawdles.	
	Helpful with adults.	
	With peers: Enjoys playing alone.	Provide opportunities for uninterrupted play.
	Enjoys having other children near but does not play with them much.	Not force children to play together.
	Pinches, kicks, bites and pushes when angry—usually caused by interference with physical activity or possessions.	Not allow children to hurt each other.
Emotional	Begins to develop sense of self. Needs to do some things for self. Enjoys praise.	Provide simple experiences in which the child can successfully do things for him/her self. Praise him/her often.
	Tests powers—says "no" often. Shows lots of emotion—laughs, squeals, throws temper tantrums violently, etc.	Be firm in following through with instructions, but do not punish the child for cries expressing feelings and independence.
	Fears loud noises, moving quickly or to high placed, large animals, mother's departure.	Avoid sudden situations involving these fears. Do not force or ridicule the child.
Moral	Child usually appears self-reliant and wants to be good, but is not yet mature enough to be able to carry out most of his/her promises.	Maintain realistic expectations of what the child can do.

Three to Four Years

	Characteristics	Parents Should...
Physical	Large muscle: Runs easily and jumps.	Carefully supervise opportunities for large muscle activity.
	Begins to climb ladders. Can start to ride tricycle. Tries everything. Is very active.	Set limits for distances. Child tends to wander too far.
	Small muscle: Dresses self fairly well. Can't tie shoes. Feeds self with spoon and fork. Likes to play with mud, sand, finger paints, etc. Begins to put together simple puzzles and construction toys.	Provide many opportunities for child to practice skills. Encourage those activities that strengthen and coordinate small muscles.
	Takes more care of own toilet needs—can stay dry all day but may not stay dry all night. Becomes very interested in his/her body and how it works.	Explain all body parts without judgment. Answer questions about body functions simply and honestly.
Mental	Continues to learn through his/her senses.	Provide many sensory experiences.
	Uses imagination a lot—starts dramatic play and role playing.	Provide props for dramatic play.
	Begins to see cause and effect relationships.	Point out and explain common cause and effect relationships – how rain helps flowers grow, how dropping makes glass break, how hitting makes a person hurt.
	Likes to learn simple songs and rhymes, likes to play around with sounds, knows more than he/she can say in words. Is curious and inquisitive.	Explain things to the child, answer questions honestly and help him put feelings into words.
Social	With adults: Can leave mother for short periods of time though she is still very important. Begins to notice differences in the ways women and men act. Imitates adults.	Be a role model. At the start of sex-role development, he/she will act as he/she sees you act.
	With peers: Starts to be more interested in others. Begins group play—likes company. Is not ready for games or competition.	Provide enough materials so that several children can use them together. Help the child find socially acceptable ways of dealing with others.
Emotional	Is anxious to please adults and is dependent on others' approval, love and praise.	Give your approval through facial expressions, gestures and verbal responses. Avoid negative remarks about the child. Emphasize the family's love for the child.
	May strike out emotionally at situations or persons when he/she has trouble.	Offer love, understanding and patience. Help him/her work with and understand his/her own emotions.
	Is sensitive to the feelings of other people toward him/herself.	Develop a warm relationship with him/her. Express and show love for and confidence in him/her.
	Is developing some independence and self-reliance.	Encourage the child to do things for him/herself.
	May have fear of unusual people, the dark, animals.	Not force the child to participate in frightening activities and don't ridicule.
Moral	Begins to know right from wrong.	Provide clear limits and enforce them consistently but not harshly.
	Finds others' opinion of him/her are important. Increase self control and less aggression.	Praise the child whenever you honestly can.

Four to Five Years

	Characteristics	Parents Should...
Physical	Average height – 40.5 inches. Average weight – 36 pounds. Is very active—consistently on the go. Is sometimes physically aggressive. Has rapid muscle growth. Would rather talk or play than eat.	 Provide plenty of play space both indoors and out. Provide for rest—he/she will tire easily. Provide ample protein in diet. Nutrition is important.
Mental	Has large vocabulary and interest in language and is fascinated by words and silly sounds. Likes to shock adults with bathroom language. Has insatiable curiosity. Asks innumerable questions—incessant talker. Can reason a little but still has many misconceptions.	Provide interesting words and stories. Play word games. Ignore bad language. Answer questions patiently. Provide experiences that will expand his/her reasoning ability such as riddles and guessing games. Clarify misconceptions.
Social	Really needs to play with others. Relationships often stormy. May exclude some from group. Likes to imitate adult activities. Good imagination, loves to pretend. Relying less on physical aggression. Is learning to share, accept rules and take turns.	Send him/her to a good nursery school or play group, if possible. Provide props for dramatic play. Help him/her learn positive social behavior without punishing or scolding. Expect him/her to take simple responsibilities and follow simple rules such as taking turns.
Emotional	Exhibits a great amount of demanding, threatening or name calling. Often is bossy or belligerent. Goes to extreme—bossy but then shy. Frequently whines, cries, complains. Often tests people to see who he/she can control. Is boastful, especially about self and family. Has growing confidence about self and world. Beginning to develop some feelings of insecurity.	Keep sense of humor. Provide outlets for emotional expression through talking, physical activity, or creative media. Establish limits and stick to them. Provide opportunities for talking about self and family. Strengthen his/her positive self concept by pointing out the things he/she can do for self. Assure him/her of your love and the love of his/her parents.
Moral	Is becoming aware of right and wrong; usually has desire to do right. May blame others for wrongdoings.	Help him/her learn to be responsible for actions and behaviors, and teach the importance of making right choices.

Five to Six Years

	Characteristics	Parents Should...
Physical	Can dress and undress self. Has tendency to be far sighted—may cause poor hand/eye coordination.	Not try to teach skills that require continued eye coordination such as reading.
	Prefers use of one hand or the other.	Not force child to change hand preference.
	Is able to care for own toilet needs.	
	Knows difference in sexes— interest lessening: more modesty, less bathroom play. Interested in babies and where they come from.	Offer simple, accurate explanation.
	Has bigger appetite. May have stomach aches or vomiting when asked to eat disliked foods.	Offer appealing variety of food without force. He/she is more sensitive to spicy food than adults.
	Prefers plain cooking but accepts wider choices of foods.	
Mental	May stutter if tired or nervous.	Not empathize – it's only temporary. Begin group experiences on half day basis.
	Will follow instructions and accepts supervision.	
	Knows colors, numbers, etc. Can identify coins.	
	May be able to print a few letters.	
Social	May fear mother won't return. Mother is the center of his/her world. Copies adults. Likes praise.	Avoid leaving until child is prepared. He/she needs mother's reassurance of return.
	Plays with boys and girls. Is calm and friendly. Is not too demanding in relations with others. Can play with one child or a group of children.	Encourage child to find activities at school he/she enjoys. Offer comfort. Provide a secure noncritical environment.
	Likes conversation during means.	Include child in adult conversation.
	If doesn't like school, may develop nausea or vomiting.	
	Is experiencing an age of conformity. Is critical of those who do not conform.	Help child learn value of individual differences.
Emotional	In general is reliable, stable and well adjusted.	
	Though not fearful, may show some fear of dark, falling, dogs, or bodily harm.	
	If tired, nervous or upset may develop tension. Outlets of nail biting, eye blinking, throat clearing, sniffling or nose twitching, thumb sucking.	Try not to appear overly concerned. Deal with cause of tension, not the habit it creates. Increases in temporary nervous habits are normal. Offer distractions. Understand child may still need rest or quiet times.
	Is concerned with pleasing adults.	Show your love.
	Is easily embarrassed.	Be sensitive to things that embarrass him/her.
Moral	Is becoming aware of right and wrong; usually has desire to do right. May blame others for wrong-doings.	Help him/her learn to be responsible for actions and behaviors, and teach the importance of making right choices.

Six to Seven Years

	Characteristics	Parents Should...
Physical	Is vigorous, full of energy, has general restlessness. Is clumsy, in an ugly duckling stage.	
	Rarely has toileting accidents—may occur when upset or over excited. May need reminders.	Accept accidents calmly. Child may be embarrassed.
	Has marked awareness of sexual differences. Investigate each other. Engages in sex play and show. May play doctor and hospital.	Will accept idea that baby grows in womb. Child is gathering information. Don't worry. It's usually just curiosity. Give honest and simple answers in a calm manner.
	Begins to suppress masturbation.	Be a role model for good habits.
	Has unpredictable food preferences and strong refusals. Often develops a passion for peanut butter. Uses fingers and talks with mouth full.	
	Has more colds, sore throats and other diseases	Be aware of disease symptoms. Ill health may result in crankiness. Child needs plenty of rest and balanced meals.
Mental	May develop stuttering when under stress. Wants all of everything. Finds it difficult to make choices.	Not offer excessive choices, but provide opportunities for making choices. Symptom is temporary and may disappear of own accord.
	Begins to have organized, continuous memories.	
	Can read and write.	
Social	Blames mother for everything that goes wrong. Identifies more strongly with father. Doesn't like to be kissed in public. Expands outside the family. Considers teacher important.	Help child to see adults care about him/her but do not attempt to replace parents.
	Friendships are unstable. Is sometimes unkind to peers. Gives negative response often. Is a tattletale. Must be the winner—changes rules to fit own needs. In school, can't keep mind on work; fools around, whispers, bothers other children.	Give guidance in making and keeping friends. Give help in learning to be a good loser. Allow time for peer interaction.
	When eating, makes meals difficult because of perpetual activity. Is not a good meal finisher.	Allow extra time for morning meal.
Emotional	Feels insecure as result of drive toward independence. Find it difficult to accept criticism, blame or punishment.	Allow needed time, leeway, more chances. Child requires patience and understanding.
	Is the center of his/her own world and his/her main concern. Is boastful.	Understand that the child needs support for independence and opportunities to do things for self.
	Generally is rigid, negative, demanding, unadaptable, slow to respond. Exhibits violent emotional extremes. Tantrums reappear. If not winner, often makes accusations of cheating.	Set reasonable limits, offer explanation of limits and help child stay within limits. Be consistent. Avoid games that designate a winner.
Moral	Is very concerned with good and bad behavior, particularly as it affects his/her family and friends. Sometimes blames others for wrongdoings.	Teach child to be concerned and responsible for own behavior and how to perfect it. Assure him, her that everyone makes mistakes. Teach simple repentance.

Seven to Eight Years

	Characteristics	Parents Should...
Physical	Large muscle: Drive himself until exhausted.	Distract child before point of complete exhaustion.
	Small muscle: Loves pencils instead of crayons.	Know: Child has well-established hand-eye coordination now.
	Is less interested in sex: Drop in sex play and experimentation. Can be very excited about new baby in the family.	
	Has less appetite. In general has fewer illnesses but may have colds of long duration.	
	May develop nervous habits or assume awkward positions.	Be patient with annoyances and do not draw attention to awkwardness.
Mental	Is eager for learning. Uses reflective, serious thinking. Thought beginning to be based on logic and can solve more complex problems. Attention span is good.	Ask thought provoking questions. Stimulate his/her thinking with open ended stories, riddles, thinking games, discussions, etc. Give opportunities for decision-making and selecting what he/she would do in a particular situation.
	Enjoys hobbies and skills. Likes to collect things and tell about things he/she has worked on, such as projects, writings and drawings. Favors reality.	Encourage the pursuit of hobbies and interests.
	Likes to be challenged, to work hard, and to take time completing a task.	Allow plenty of time to accomplish a task. Most stories and situations should deal with reality. Give challenges right for his/her level of ability.
Social	May have permanent pout on face. Will avoid and withdraw. Has strong emotional response to teacher—may complain teacher is unfair or mean.	Show understanding and concern.
	Likes more responsibility and independence.	Assign responsibility and tasks he/she can carry out and then praise him/her for effort and accomplishment. Help him/her assume responsibility for wrongdoing.
	Is often concerned that he/she will not do well.	
	Participates in loosely organized group play. Concerned with self and how others treat him/her. May fight or battle out problems.	Provide peace and quiet. Attempt to prevent conflicts before they get to fighting stage.
	Starts division of the sexes—girls play with girls and boys play with boys.	
	May fear being late to school, has trouble on the playground—"Kids are cheating" or "I'm going to run away".	Help child see his/her interactions realistically.

Seven to Eight Years

	Characteristics	Parents Should...
Emotional	Complains a lot: "Nobody likes me". May not respond promptly or hear directions—may forget. Is easily distracted. May stay on the edge of the scene in an attempt to build a sense of self through observation. Is attempting to control nervous habits, but blinking, scowling, headaches and dizziness appear. Visual fears: night, scary places, people. Is less domineering or determined to have own way. Dislikes criticism; is eager for peer approval. Wants to please peers and be like age group.	Give reasonable sympathy. Remind and check. Offer personal support and reassurance. Continue to help the child develop social skills. Give praise for positive behavior such as waiting his/her turn, sharing, and giving other children a chance to express their ideas. Build his/her confidence; instead of criticizing, look for opportunities to give approval and affection. Accept need for peer approval and need to belong.
Moral	Is more sensitive to own and others' feelings. Is often self-critical and a perfectionist, dreamy, absorbed and withdrawn. More inhibited and cautious, less impulsive and self-centered.	Offer love, patience, and sensitivity. Let child know he/she has progressed, and continue to encourage him/her. Accept moods and aloofness. Encourage the child to express him/herself and turn interest to others.

Eight to Nine Years

	Characteristics	Parents Should...
Physical	Is busy, active, speedy, has frequent accidents, makes faces. May need to urinate in connection with disagreeable tasks. May handle genitals if worried. Tells dirty jokes—laughs and giggles. May peep at each other and parents. Wants more exact information about pregnancy and birth. May question father's part. Has good appetite; wolfs down food. Belches spontaneously. May accept new foods. Has improved health and few short illnesses.	Continue to be available to answer questions.
Mental	Wants to know the reason for things. Often overestimates own ability. Often cries if fails—"I never get anything right."	Explain simply and patiently. Direct child toward attempting what he/she can accomplish, but still provides a challenge. Stress what the child has learned, not the end product.
Social	Demands close understanding with mother. Makes new friends easily, works at establishing good two-way friendships. Enjoys school; tends to talk more about school and doesn't like to miss. Develops close friend of own sex—separation of the sexes. Considers clubs and groups important. Is not as interested in table conversation; will want to finish meal and go on with own business. May become sensitive to the killing of animals for food.	Provide opportunity for peer interaction not only on a personal level but also on a group and club basis. Offer simple explanation for the killing of animals for food—remain understanding of his/her feelings.
Emotional	Has more "secrets". May be excessive in self-criticism —tends to dramatize. Is very sensitive. Has fewer, more reasonable fears; may have some earlier tension patterns but will be less persistent. May argue and resist requests and instructions, but will obey eventually. Could want immediate (cash) reward. Is usually affectionate, helpful, cheerful, outgoing, and curious; but can also be rude, selfish, bossy, and demanding—and giggly and silly.	Needs a locked box or drawer. Praise; do not criticize. Encourage efforts and let cild know you see his/her progress. Teach that others also make mistakes. Keep directions simple and avoid unnecessary urging in order to avoid the "I already know" response. Guide him/her toward overcoming negative emotions and developing positive ways of showing interest and enthusiasm. Let him/her enjoy humor when appropriate and be patient with giggling.
Moral	May experience guilt and shame.	Do not compare one child with another. Praise and build self confidence.

Nine to Ten Years

	Characteristics	Parents Should...
Physical	Active, rough and tumble play is normal, especially for boys. Great interest in team games. Has good body control. Is interested in developing strength, skill and speed. Likes more complicated crafts and shop work. Girls are beginning to develop faster than boys.	Provide many activities to sustain interest. Include team games. Give opportunity for developing skills such as handicrafts and active games. Include many activities in which he/she uses hands and has opportunity to use small muscle skills. Not compare boys to girls or force them to interact.
Mental	Has definite interests and lively curiosity; seeks facts. Capable of prolonged interest. Can do moreabstract thinking and reasoning. Likes to memorize. Individual differences become more marked. Likes reading, writing and using books and references. Likes to collect things.	Give specific information and facts, use child's interest. Do not give all the answers. Allow time to think: mediate and discuss. Respect and be aware of individual differences when making assignments and giving responsibilities. Provide opportunity for reading, writing, and checking references. Help with hobbies.
Social	Boys and girls differ in personalities, characteristics and interests. Still very group and club oriented but is always with same sex. Sometimes silly within the group. Boys especially, begin to test and exercise a good deal of independence. Friends and activities absorb him/her. Likes group adventures and cooperative play.	Accept natural separation of boys and girls. Recognize and support the need they have of acceptance from peer group. Be warm but firm. Establish and enforce reasonable limits. Encourage friendships and help children who may have few or no friends.
Emotional	Worries. May have some behavior problems, especially if he/she is not accepted by others. Is becoming very independent, dependable and trustworthy. Is very conscious of being fair. Is highly competitive. Argues over fairness. Has difficulty admitting he/she behaved badly or made a mistake; but is becoming more capable of accepting his/her own failures and mistakes and takes responsibility for own actions.	Use positive guidance, let him/her know you accept him/her even though you do not approve of his/her behavior. Provide many experiences for exercising independence and dependability. Praise those positive characteristics. Be fair in dealings and relationships with him/her. Give opportunities for competing, but help child learn to be a good loser. Not ridicule or tear him/her down for wrongdoings but help him/her learn to take responsibility for own behavior.
Moral	Is clearly acquiring a conscience. Is well aware of right and wrong; wants to do right but sometimes overreacts or rebels against an overly strict conscience.	Express your love and support for him/her often.

Ten to Eleven Years

	Characteristics	Parents Should...
Physical	Girls are concerned with style. Girls may begin a rapid increase in weight. Boys are more active and rough. Has motor skills well in hand. Has 14-16 permanent teeth.	Help with nutrition.
Mental	Is alert, poised. Argues logically. Begins to use fractions. Likes to read. Has rather short interest span. Begins to show talents. Concerned with facts.	Use reasoning. Provide books geared to interests. Provide lessons for music, art, or other interests. Good time to discuss drug abuse.
Social	May develop hero worship. Is affectionate with parents. Finds mother all important. Is highly selective in friendship—may have one best friend. Has great pride in father. Important to be "in" with the group.	Spend time with the child. Spend time with the child.
Emotional	Is casual and relaxed. Likes privacy. Girls maturing faster than boys. Seldom cries but may cry in anger. Not typically an angry age. Anger, when it comes, is intense and immediate. Main worry concerns school and peer relationships.	Provide cabinet or box for "treasures" and a "keep out" sign for the door.
Moral	Has a strong sense of justice and a strict moral code. More concerned with what is wrong than with what is right.	Maintain consistency. Be aware that children at this age will be very concerned with behavior that they see as hypocritical. Model behavior that you want to see the child imitate.

Eleven to Twelve Years

	Characteristics	Parents Should...
Physical	Girls begin to show secondary sex characteristics. Boys are ahead of girls in endurance. Is increasingly aware of body. Has increase in muscle growth. May show self-consciousness about learning new skills.	Explain menstruation. Let child take the initiative. Rapid growth may mean large appetite but less energy.
Mental	Challenges adult knowledge. Has increased ability to use logic. May have interest in earning money. Is critical of own artistic products. Is interested in world and community.	Let child try a paper route or other job if he/she wants. Let child participate in community drives they may be interested in.
Social	Is critical of adults. May be quiet around strangers. Strives for unreasonable independence. Has intense interest in teams and organized, competitive games. Considers membership in clubs important.	Provide for organized activities in sports or clubs.
Emotional	Anger is very common. Resents being told what to do. Rebels at routines. Often is moody. Dramatizes and exaggerates his/her expressions, "worst mother in the world". Many fears, many worries, many tears.	Let child help set the rules and held decide on own responsibilities. Be understanding.
Moral	Has strong urge to conform to group morals.	Keep the lines of communication open.

Twelve to Fifteen Years

	Characteristics	Parents Should...
Physical	Onset of adolescence is usually accompanied by sudden and rapid increases in height and weight. Girl has gradually reached physical and sexual maturity. Boy is beginning physical and sexual maturity. Development is rapid. Acne. Physical strength increases greatly. Concerned with appearance.	Understand child will need more food. Explain to child what is happening—not to worry if not like all the rest. Consult a physician. May need special diet—medication to treat acne.
Mental	Thrives on arguments and discussions. Ability to memorize usually increases. Ability to think logically about verbal positions. Developing ability to introspect and probe into own thinking. Able to plan realistically for the future. Idealism. Reads a great deal.	Not let discussions become arguments. Not put down his/her ideas for they are truly his/hers, but do help him/her to see the reality. Understand child needs to feel important in the world, to know they have something to believe in, a cause to fight for.
Social	Withdraws from parents who are "old fashioned". Boys usually resist any show of affection. Usually feel parents are too restraining. Needs less family companionship and interaction. Rebels. Has less intense friendships with those of the same sex. Usually has a whole group of friends. Girls show more interest in the opposite sex than do boys. Annoyed by younger siblings.	Not feel hurt or take it personally. Remember you are still important, but not in the same way as when they were children. Understand his/her need to be independent.
Emotional	Sulking is common. Fewer anger responses, but main ones are verbal retorts and then may leave. More worried than fearful about grades, appearance, popularity. Withdrawn, introspective.	Not take it personally. Fitting in with friends and searching for identity as a person is important to him/her.

Twelve to Fifteen Years

	Characteristics	Parents Should...
Moral	Knows right and wrong. Tries to weigh alternatives and arrive at decisions by him/herself. Is concerned about fair treatment of others. Is usually or reasonably thoughtful. Isn't likely to lie, but doesn't always tell the whole truth.	Give opportunities Be available.

Fifteen to Nineteen Years

	Characteristics	Parents Should...
Physical	Has essentially completed physical maturity. Physical features are shaped and refined.	Understand youth needs less food.
Mental	May need some special testing to help determine future educational plans. If he/she reads, tends to read exhaustively. Prefers the books and magazines of adults.	Help arrange testing at school. Encourage talking about the future.
Social	Can maintain friendly relationships with parents. Sometimes feels parents are too "interested". Dates actively—varies greatly in maturity. Some are uncomfortable with opposite sex while others talk of marriage. Enjoys activities with friends of the opposite sex. Usually has many friends and few confidants. May have a job.	Try not to pry.
Emotional	Worried about the future— what to do. Anger responses less frequent. Still worries about appearance.	Be available to talk and listen.
Moral	Knows what is right and wrong, but doesn't always do right. Thinks more like his/her parents. Takes blame well and is not so likely to blame others without just cause. Wants to find the meaning of life and feel secure in it.	Be positive and encouraging.

Discipline

Discipline is a method of educating and training a child in the areas of self-control, character, orderliness, and efficiency. Punishment differs from discipline in that punishment controls a child's behavior by the use of force or authority. Discipline does not involve force or authority; instead, it promotes responsibility and encourages ongoing communication.

The most important factor regarding discipline is the child/caregiver relationship. Ongoing communication between the foster parent and the child provides the child with information as to how their behavior affects the way others see and relate to them. Some foster parents have not had the benefit of a long-term relationship with the foster child. The trust and bond that foster parents probably have with their own child are not necessarily present with the foster children. Therefore, techniques that may be effective with their own child may be ineffective or lead to mistrust between the foster child and foster parents. Many children who have been severely physically abused may not react to a "typical" spanking, while others may be traumatized due to memories of the past. By implementing an appropriate discipline plan, it is more likely that foster children will learn how to appropriately raise their own children.

Guidelines for the Use of Discipline

Here are general guidelines for use when disciplining a child in any way:

1. Use encouragement and praise whenever possible to reinforce behavior;
2. Take corrective action to implement discipline only after the anger toward the behavior subsides;
3. Determine several discipline options to deal with a specific behavior or set of behaviors before taking action;
4. Set clear limits, rules, and expectations and communicate these to the child;
5. When possible have the children take responsibility for their actions and correct the behavior or situation;
6. Give the children choices and involve them in decision-making to assist them in developing internal controls;
7. Make consequences immediate when possible; and,
8. Take into consideration the physical, emotional, or mental abilities or limitations that impede their ability to understand what is expected of them and to behave accordingly.

Discipline Teaches Consequences

Discipline involves teaching children that their behavior results in certain consequences. There are three different types of consequences: natural, logical and artificial (Ryan, 1988).

Natural consequences are those that occur without any intervention by a foster parent. For example, if you stay up too late at night, you will be tired the next day. Logical consequences are those that are put into effect by the foster parent when the behavior and consequences are directly related. For instance, if you stretch a curfew to come home, the next time the curfew is set for an earlier time.

Artificial consequences are those that are put into effect by the foster parents, but there is no clear relationship between the behavior and the consequences. For example, if a child stays out later than their curfew, they will not be allowed to watch television the next day. These three types of consequences can be seen as a continuum, with the logical consequences being the most effective and the artificial consequences being the least effective. All consequences have some effect, given the situation and how the child or foster parent interprets it, but it is best to rely mostly on "natural" and "logical" consequences.

Methods

Following is discussion of several methods of discipline that encourage responsibilities and internal control in children: contracts, behavior management, and corrective action.

Contracts

Contracts are statements, spoken or written that the foster parent and the child negotiate. Contracts can be simple and a convenient method to help a child acquire self-discipline because they:

1. Involve the child in decision-making and encourage taking responsibility for their own actions;
2. Are flexible and can be negotiated to meet the requirements of the situation;
3. Can be tailored to meet the individual child's needs;
4. Provide opportunities for success that are visible to the child;
5. Are a tool that requires children to examine themselves in terms of their capacity for self-direction;
6. Increase in complexity as the child assumes greater self-responsibility;
7. Provide opportunities for interaction between the child and the foster parent;
8. Provide the child with practice for adult life; and
9. Provide a shared investment by the child and the foster parent.

Behavior Management

A second form of encouraging internal control and personal responsibility is called behavior management. If a child is not able to manage self-discipline, the foster parent may need to impose structure, so responsibility may be turned over to the child slowly. Behavior management is usually done through a system of incentives. The child receives rewards (privileges or tokens) for approved behavior and can usually work up to a level of increased self-responsibility. Behavior management works best if:

1. The rewards are established with mutual agreement from the child and the foster parent;
2. Everyone involved follows the plan consistently; and
3. The child is rewarded when they behave appropriately. If the child does not perform appropriate behaviors, then the child is not to be rewarded (but the child should never be asked to return a reward).

Example:

Desired behavior	Brushing teeth before bedtime.
Behavior management	Offer the child tokens or coupons each time the child brushes before bedtime.
Reward	After the child has earned ten tokens or coupons, the child will receive the reward *(i.e. extra TV time, bonus in allowance, favorite food, etc. However, be careful about over-using food and money as rewards.)*

Corrective Action

Corrective action identifies a problem behavior, creates a plan to change the behavior, evaluates the results, and then offers an opportunity to adjust the plan.

Provided below are seven techniques that may be used in a corrective action plan. Before deciding to take corrective action, the foster parent must decide first if the behavior in question can be permitted, tolerated for a time, or simply ignored. Other factors to consider include the child's age, stage of development, and the seriousness of the child's behavior. Children must be given opportunities to recognize when their behavior is inappropriate and to learn how to control it themselves.

1. **Clarification:** For disciplinary action to be effective, the exact behavior must be identified to the child, when it occurred, who provoked it, who the offenders were, and under what circumstances it took place.
2. **Persuasion:** Following clarification, the foster parent is to try to persuade the child to correct the mistake. They can show the child that there are other ways of achieving the goal, that the child has the ability to control impulses, and that the child is more capable than the child may believe. The foster parent's tone must be supportive, emphasizing the realistic consequences of the offense and suggesting how it could be corrected. The child may be able to suggest ways of correcting the mistake.
3. **Distraction:** Sometimes the simplest way of correcting a child is to draw the child's attention to a substitute activity. The choice of the substitute activity should be guided by the following criteria - the child's interests, his/her social acceptability and age appropriateness of the substitute activity, and its capacity to diminish the problem behavior of the original activity.
4. **Interference:** There are times when the foster parent must immediately stop the unacceptable behavior. Verbal interference tells the child that "since you cannot control yourself, I will help you control yourself". Interference could be in the form of accompanying the child in order to prevent a behavior. Physical restraint such as holding could be used for the child's protection or to prevent injury to another child or damage to property. However, training must be sought first in the proper and safe use of physical restraint.
5. **Time out:** Time out involves removal of the child from a situation until the child calms down. The child can be isolated in a chair, in another part of the room, or in the child's own room if the child is older. In some situations, it may be appropriate for the foster

parents to take "time out" by leaving the situation as long as the child's safety is not in question. Also, time out:

a. Should be used sparingly, after other techniques have failed to bring the child under control;

b. Should be of short duration (one minute per year of the child's age; e.g. ten minutes maximum for a 10 year old child); and

c. When a time out is over and the child has calmed down, the child should return to a constructive activity that can redirect the child's energy.

6. **Withholding privileges:** At times, it may become necessary to withhold privileges as a means of changing a child's behavior. A privilege is a benefit or favor that is granted to the child and have to be given to the child before they can be withheld. Examples of privileges that could be withheld include use of the telephone, walks to the store, and watching television. Extra snacks may be withheld but meals may not be.

7. **Restitution:** Restitution is a realistic and simple form of discipline in such cases as property damage or theft. The child should pay for the repair or replacement of the property, within reason, from an allowance, part-time job, etc. A child who steals can either return the stolen goods or pay for them.

See updated *Child Welfare Policies, Chapter 8, Out of Home Services, Section 18, Discipline,* ***http://www.in.gov/dcs/2533.htm***

"Children need love especially when they do not deserve it."

—Harold Shulbert

Essential Connections

Visitation with the Biological Family

It is the fundamental right for children to visit with their parents and siblings. *The relationship developed by the child with the parent is one of bonding, dependency, and being nurtured; all of which must be protected for the emotional well being of the child. It is of extreme importance for a child not to feel abandoned in placement by either the child's parents or by other siblings. It is also important for a child to be reassured that no harm has befallen either parent or siblings when separation occurs.* ***Under no circumstance should a child be deprived of visitation as a form of discipline.***

Visit facilitation will be provided between parents/children and/or siblings only who have been separated due to a substantiated allegation of abuse or neglect. Visitation allows the child an opportunity to reconnect and reestablish the parent/child/sibling relationship in a safe environment. It is an excellent time for parents to learn and practice new concepts of parenting and to assess their own ability to parent through interaction with the child.

Visitation can be used to define the degree of change that must occur prior to the return of the child. As progress is made and return is imminent, increased visitation can ease the transitional period when the child moves from a foster home back into the home of the legal parents. In situations where reunification is not the goal for the family and siblings who have been separated, sibling visitation may be provided.

Visitation may be held in a visitation facility; neutral sites such as parks, fast food restaurant with playground, or shopping malls; child's own home or relative's home; foster home; or other location as deemed appropriate by the referring DCS and other parties involved in the child's case taking into consideration the child's physical safety and emotional well being.

Through careful and complete documentation of visitation, family case managers and the foster parent(s) can better provide the court with necessary information to help in decision-making

regarding the child. It is important for the foster parent(s) to discuss with the family case manager and/or child's therapist the child's behavior both prior to and after the visit with the parents as well as any other pertinent observations the foster parents may make concerning the visit.

Foster Parent Role in Visitation

Visitation between the child and the legal family is one of the most important factors in returning the child home to their legal parent(s). The degree of foster parent involvement in visitation should be a mutual decision reached through a consensus building process involving the foster family, the child's counselor/therapist, CASA/GAL, and the family case manager frequently involving a Child and Family Team Meeting. Ongoing visitation supports and strengthens the child's relationship and trust with their parents. Foster parents can support the foster child-legal parent relationship by preparing the child for visits and encouraging open expression of feelings about the visits. Foster parents may discuss with the foster child their feelings about being separated from their legal parents and help them with their grief about the separation.

It is extremely important that foster parents respect the confidential nature of all information received regarding the child and their legal parents and that they refrain from demeaning the child's parents or relatives when in the presence of the child or others.

The number of visits per week may vary based on the situation that brought the child into care. When the foster child is an infant, visitation may be scheduled daily in order to allow the child to continue to bond with the parents. All visitation schedules are individualized to allow maximum contact that will provide for safe and positive interaction between the child and parents. Because each family situation is different, visitation schedules and the level of supervision at visits will vary. You should discuss the Visitation Plan with the child's family case manager to be clear about the expectations for scheduling and arrangements. Any visitation arrangements made outside of what has been ordered by the court or scheduled in the Case/Visitation Plan, must be approved by the County Department of Child Services due to safety issues.

See updated *Child Welfare Policies, Chapter 8: Out of Home Services, Section 12 and 13,* ***http://www.in.gov/dcs/2533.htm***

See *Manual, Chapter 4: Children in Care*

The Sibling Bond

The bond between brothers and sisters is unique. It is the longest lasting relationship most people have, longer than the parent/child or husband/wife relationship. This bond exists in children reared in well-adjusted families, but is often stronger for brothers and sisters from dysfunctional families. They learn very early to depend on and cooperate with each other to cope with their common problems. Separating siblings in foster care adds to their emotional burden. Biological siblings share the same genetic makeup. Sometimes, it is only through their siblings that children have been able to gain any positive self-esteem. Biological siblings share past experiences and family history. Children need to integrate their past with their future in order to have continuity and to develop a clear understanding of their identity. Siblings who remain together learn how to resolve their differences and develop strong relationships. It is the responsibility of DCS to maintain this sibling bond throughout the child's involvement with the agency whenever possible.

Educational Needs and Services

"Do not limit a child to your own learning for he was born in another time."

—Rabbinical saying

Educational Terminology You Should Know

Educational Surrogate Parent—An educational surrogate parent is a parent, foster parent or volunteer over the age of 18, who has been trained to assume the responsibility of representing a child with disabilities in the educational system whose own parent is not available or who is a ward of the DCS and living in foster care. Foster parents may serve as surrogate parents if they have received training and been assigned by the director of the local school corporation special education program.

Individual Education Plan (IEP)—If your foster child is in special education or receiving specialized services due to a disability, he/she must have an IEP, created by the school the child attends and with the input of all parties involved with his/her education or training. The IEP addresses how the school will meet the child's individual educational needs.

Individual Transition Plan (ITP)—When your student receiving special services will be moving from one educational facility to another (moving from pre-school to school services, from elementary school to high school, or from high school to adult services), an ITP will be written to guide how that transition will take place. Again, all appropriate parties will have input (those from the program the child is leaving as well as those from the program he/she will be attending).

The Special Education Cooperative (Co-op)—Often small school corporations will not have enough special students to maintain a quality program and will work with one or more neighboring areas to form a cooperative program. Students may be bussed longer distances when this happens; however, their program will likely be of higher quality.

Disorders or Conditions for which Special Services are available—

Autism spectrum disorder
Communication disorder
Deaf-blind
Developmental Delay
(Early Childhood)
Emotional disability
Hearing impairment
Learning disability
Mental disability
Multiple disabilities
Orthopedic impairment
Other health impairment
Traumatic brain injury
Visual impairment

Infants and Toddlers

Early Head Start

www.headstart.com

Early Head Start is a Federal program for children and families that serve pregnant mothers and children up to their third birthday. Children can participate in activities that will help them grow mentally, socially, emotionally and physically. Early Head Start children receive medical assessments, mental health services and follow up services. Talk with the child's case manager if you feel a child in your care will benefit from this or any other educational service.

First Steps

www.indianafirststeps.com

First Steps is Indiana's implementation of Part C of the Individuals with Disabilities Education Act (IDEA), providing services to infants and toddlers from birth to age 3 and their families. Eligible children are those under age 3 who have a developmental delay or have a medical diagnosis or a biological risk factor that has a high probability of leading to developmental delays. An evaluation can be provided on request. Services are individualized and are available in all 92 counties in Indiana.

Several of the services included through the program are—

Assistive technology
Developmental therapy
Medical services*(for diagnosis only)*
Nutrition services
Physical therapy
Service coordination
Speech therapy
Audiology
Health services
Nursing services
Occupational therapy
Psychological services
Social work services
Vision services

First Steps services are voluntary on the part of the family. Services are written into an Individualized Family Services Plan (IFSP) that is developed by a services coordinator, the parent, and the providers who participated in the eligibility determination. In the event that the parents are not available, the coordinator will assign a surrogate parent (usually a foster parent) to participate in the IFSP development and sign permission for services to begin.

Early Childhood to School Age

Local School Corporation

As a part of the continuum of compliance with the Individuals with Disabilities Education Act the local school corporation will provide special services for students with disabilities from the day of the eligible child's third birthday through age four (and through age five when appropriate). Instruction in early childhood programs can be through consultation, part-time or full-time classes and/or home based instruction provided within the local school structure or through a contract with a public or private agency.

Head Start *www.headstart.com*

For children in this age group who do not have a diagnosed developmental delay but who will benefit from socialization and enriching experiences, Head Start programs are available in all Indiana Counties. They are open to children ages three (3) through five (5) who meet the federal income guidelines, with priority given to four (4) and five (5) year old children the year prior to kindergarten.. Transportation is also available. Children who attend Head Start participate in a variety of educational activities. They also receive free medical and dental care, have healthy meals and snacks, and enjoy playing indoors and outdoors in safe settings.

School Age

General/Specialized Education

Most children, even those with special needs, can be well served by participating in general education programs when they reach school age. However, some students may have difficulty functioning within the regular classroom setting, whether it is difficulty walking, talking, seeing, hearing, or learning. Specialists, teachers, administrators and parents/ foster parents may cooperate to make changes in the general education program, materials, or instructional techniques to resolve the difficulties. Please talk with the child's case manager if you feel that a change is needed in the educational program of your foster child.

In*Source: Indiana Resource Center for Families with Special Needs

IN*Source provides parents, families and service providers with the information and training necessary to assure effective educational programs and appropriate services for children and young adults with disabilities. IN*Source also offers Educational Surrogate Parent Training and other parent advocacy seminars for families who are parenting children with special needs.

They can be reached at: (574) 234-7101 (or *Toll Free*) 1-800-332-4433 *(Phone)*
(574) 234-7279 *(Fax)*
insource@insource.org *(E-mail)*
www.insource.org *(Internet)*

Post Secondary Education

21st Century Scholars Program

The 21st Century Scholars Program began in 1990 as Indiana's way of raising the educational aspirations of low- and moderate-income families. The program aims to ensure that all Indiana families can afford a college education for their children.

Income-eligible 7th and 8th graders who enroll in the program and fulfill a pledge of good citizenship to the state are guaranteed the cost of four years of college tuition at any participating public college or university in Indiana. If the student attends a private institution, the state will award an amount comparable to that of a public institution. If the student attends a participating proprietary school, the state will award a tuition scholarship equal to that of Ivy Tech State College.

Eligible students may apply to the 21st Century Scholars Program and must:

- Be a resident of Indiana both at the time of application and receipt of award;
- Be enrolled in the 7th or 8th grade at a charter school, freeway school, or other Indiana school accredited by the IDOE;
- Meet income requirements or be a ward of the court, county, or in foster care.
- Make a commitment to fulfill the Scholars Pledge:
- I will graduate with an Indiana High School Diploma;
- I will achieve a cumulative high school GPA of at least 2.0 on a 4.0 scale;

- I will not use illegal drugs or alcohol, or commit a crime;
- I will apply for admission to an eligible Indiana college, university or proprietary school as a high school senior;
- I will apply on time for state and federal financial aid.

Under certain circumstances, the requirement to apply during the 7th or 8th grade can be waived for students past those grades who come into foster care. Please talk to the school counselor and enroll your student.

For more information, please go to the 21st Century Scholars Program website, ***www.in.gov/ssaci/***

Independent Living Program Transition Services, College or Vocational Training

Nationwide, statistics show that a significant number of the homeless population are young adults who have aged out of the foster care system. Often without room and board assistance, foster parents cannot continue to provide these youth a home. Many have lost contact with their birth families or, often even though that tie has been maintained the birth family is also not a source of support. Other times, there is simply a strong desire on the part of the teen to be independent, to be "free of the system". Teens that are unprepared for this "independence" may quickly face some harsh realities.

Indiana has developed a comprehensive independent living program that begins when the teen in foster care reaches age 16. Services provided are age-appropriate and tailored to the individual teen's needs; focusing not only on keeping the teen in school to graduation or to completion of a GED, but also on developing a plan when foster care cannot continue and acquiring the needed skills necessary to carry out that plan. The IL program also offers opportunities to attend yearly seminars and workshops with other teens from all over Indiana and to develop leadership skills through serving on a youth board or participating in internships.

When a child's ward ship is dismissed the independent living program can provide transition services that include financial help for housing either in an apartment or continuing on a room and board basis with the foster parents. Mentoring by a responsible adult from the community assists the teen with adjusting to the new situation and with job search.

For those teens who wish to further their education, tuition assistance for college or vocational training is available through the Education and Training Voucher program. Fees for taking the SAT or other entrance exams are waived. Planning for college or vocational training must begin early. First there is the empowerment part - encouragement from teachers, the FCM, the foster parents, the mentor, and all other responsible adults in the teen's life, that college or a vocational program is possible and that he/she is capable and can master it with their help. Then there is the actual work of filling out all the applications and financial aid forms that are a part of this process! This can be a stressful time for your teen, but it is also a memorable time that is truly the beginning of his/her passage to adulthood. For more information about the Education and Training Voucher program, talk with your foster child's IL provider or visit the website, ***www.StateVoucher.org.***

See Updated Child Welfare Policies, Chapter 11, Independent Living,
http://www.in.gov/dcs/2530.htm

Orphan Foundation Scholarships

Still another possible resource for aid to foster children for the payment of college expenses is the Orphan Foundation Program. To be eligible, applicants must:

- Have been in foster care for one consecutive year at the time of their 18th birthday or high school graduation, or,
- Have been adopted or taken into legal guardianship out of foster care after their 16th birthday; or,
- Have lost both parents to death before the age of 18 and not been subsequently adopted; and,
- Be accepted into or enrolled in an accredited post-secondary program (university, college, community or vocational/technical institute).
- Be under the age of 25 at application.

For information regarding this resource, see the website:
http://www.orphan.org/scholarships.html.

Tuition Exemption

Established by Indiana Legislative Code (IC 20-12-19)

Under Indiana law, prospective college students who meet certain requirements are entitled to receive free college tuition and fees. Those requirements are that the prospective student be:

- A student at the Soldiers and Sailors' Children's Home;
- Admitted to the Soldiers and Sailors' Children's Home because the student was related to a member of the armed forces of the US;
- Eligible to pay the resident tuition rate at the state educational institution the pupil will attend;
- Able to meet the required academic qualifications; and,
- A student whose father or mother:
  - Served in the armed forces of the US;
  - Received the Purple Heart decoration or was wounded as a result of enemy action; and
  - Received a discharge or separation from the armed forces other than a dishonorable discharge;
- Or a student whose father or mother:
  - Served in the armed forces of the US during any war or performed duty equally hazardous that was recognized by the award of a service or campaign medal of the US;
  - Suffered a service connected death or disability as determined by the US Department of Veterans Affairs; and

- Received a discharge or separation from the armed forces other than a dishonorable discharge.

Your school guidance counselor is the best resource for further information concerning this scholarship program.

Child Health

Recommended Immunizations (2006)

Recommended Immunizations (2006)	Birth	Month 1	2	4	6	12	15	18	24	Years 4-6	11-12	13-14	15	16-18
Hepatitis B	1st	2nd			3rd									
Hepatitis A						Two*								
Inactivated Poliovirus			1st	2nd	3rd					4th				
Rotavirus			Three											
Haemophilus Influenza Type B			1st	2nd	3rd	4th								
Measles, Mumps, Rubella						1st				2nd				
Pneumococcal Conjugate			1st	2nd	3rd	4th								
Diphtheria, Tetanus, Acellular Pertussis			1st	2nd	3rd		4th			5th				
Tetanus, Diphtheria and Acellular Pertussis											1st**			
Varicella						1st***								
Influenza					Yearly****									
Meningococcal													1st	
Human Papillomavirus											Three*****(Female 9-26)			

Source: Center for Disease Control and Prevention

* Second dose should be 6-18 months after first dose.

** Booster shot recommended every 10 yrs through adulthood.

*** Second dose recommended at 4-6 yrs but not yet recommended by the CDC.

**** Shot also recommended for children 2–5 yrs.

***** Series can start in girls as young as 9 yrs old.

Medical Terminology to know

Indiana Medicaid—Indiana's medical program that can pay the costs of medical, dental, and eye care for your foster child.

Medicaid Card—This card will be given to you to verify your foster child's eligibility for medical care through the Medicaid program. Please keep the card in a safe but handy place and remember to take it with you when you take your child to medical appointments. It is very important to carry this card when you are traveling with the foster child.

Preventive Care (Well-child care)—Regularly scheduled medical, dental and optical check-ups for your child that will document his/her progress and may prevent problems from developing.

Medical Passport—Tool that has been established for use by a foster parent to maintain a written record of a foster child's medical and dental care while in out-of-home placement. When a foster child is placed with you, a Medical Passport (often times referred to as "The Bluebook") will be given to you that will contain as much medical information about your foster child as available to the FCM. When you take the child for further appointments of any kind, take the Bluebook and give it to either the doctor or the nurse to make an entry documenting the care the child receives. When the FCM comes to visit you and the child, talk about any new entries that have been made as the FCM keeps a separate record.

See Child Welfare Policies: Chapter 8, Section 28 and 29, Maintaining Health Records (Medical Passport), ***http://www.in.gov/dcs/2533.htm***

The Impact of Substance Abuse on Foster Care[12]

Increasing numbers of children and youth who enter foster care because of abuse and neglect by chemically involved parents bring with them their own substance abuse problems. In one study, 19% of adolescents surveyed reported drinking alcohol while in out-of-home care, a rate comparable to a random sample of high school students. However, 56% reported using street drugs (marijuana, cocaine, etc.), a much higher percentage than the general population of high school students. These youth also tend to continue their drug use after leaving foster care. The drug habits of youth in foster care can seriously impede their chances of continuing their education or finding employment, often with dire consequences. It is unknown how many youth in foster care become homeless once they reach the age of emancipation, but many youth involved in substance abuse do experience bouts of homelessness. Federally funded runaway and homeless youth shelters report that 22% of homeless youth and 20% of runaway youth abuse alcohol and other drugs; urban studies report higher rates, ranging from 70% of runaways in New York City to almost 100% in San Francisco.

Possible warning signs of adolescent drug/alcohol abuse:

1. **Physical**—Fatigue, repeated health complaints, red and glazed eyes, and a persistent cough
2. **Emotional**—Personality change, sudden mood changes, irritability, irresponsible behavior, low self-esteem, poor judgment, depression, and a general lack of interest.
3. **Family**—Starting arguments, breaking rules, or withdrawing from the family.
4. **School**—Decreased interest, negative attitude, drops in grades, many absences, truancy, and discipline problems
5. **Social**—New friends who are less interested in standard home and school activities, problems with the law, and changes to less conventional styles in dress or music.

Please note that some of these signs are seen in children regardless if they have a substance abuse problem or not. Many foster children may experience these warning signs simply because they are trying to adjust to new environments or because they are acting out. In addition, many of these signs may be signs of other problems (i.e., depression). These warning signs are used primarily as helpful guidelines to caregivers. Please talk to your child's case manager immediately if you suspect that they child may have a problem.

Fetal Alcohol syndrome (FAS)[13]

Fetal Alcohol Syndrome describes a wide range of birth defects that can include physical, mental and behavioral problems caused by alcohol consumption by the mother during pregnancy. It is a continuum ranging from mild intellectual and behavioral issues to the extreme. These issues often lead to profound disabilities or premature death. At the mild end, damage may be the loss of some intellectual functioning (IQ), visual problems and higher than normal pain tolerance.

At the severe end, damage may be—

severe loss of intellectual potential,
severe vision problems,
dyslexia,
serious maxilo-facial deformities,
dental abnormalities,
heart defects,
immune system malfunctioning,
behavior problems,
attention deficit disorder,
hyperactivity,
extreme impulsiveness,
poor judgment,
little or no retained memory,
deafness,
little or no capacity for moral judgment
or interpersonal empathy,
sociopathic behavior,
epilepsy,
tremors,
cerebral palsy,
renal failure,
heart failure,
death.

Early intervention is a critical element in determining the prognosis for a child with FAS. The earlier the medical, clinical and educational interventions provided the better the outcome. Stable, structured, nurturing environments are necessary to support the child's growth and development. Special needs pre-school programs and a focus of treatment on establishing healthy parent/child relationships, motor and language development, and sensory processing development are essential. Meeting the caretaker's needs is also important since caring for these children is especially taxing. Education, support, and respite services are essential to maintaining positive parent child relationships and stability in the home setting, whether in their own home or the foster home. If you are parenting a child with FAS, the following suggestions may be helpful in dealing with the behavior problems associated with the syndrome:

- Implement daily routines to which your child can become accustomed.
- Create and enforce simple rules and limits.
- Point out and use rewards to reinforce acceptable behavior.
- Because many children with FAS are naive, guard them against "being taken advantage of" by others. Also, encourage them to make decisions in protected environments.
- Teach your child skills for daily living

Hepatitis[14]

The word hepatitis simply means an inflammation of the liver without pinpointing a specific cause.

Someone with hepatitis may:

- have one of several disorders, including viral or bacterial infection of the liver
- have a liver injury caused by a toxin (poison)
- have liver damage caused by interruption of the organ's normal blood supply
- be experiencing an attack by his or her own immune system through an autoimmune disorder
- have experienced trauma to the abdomen in the area of the liver

Hepatitis is most commonly caused by one of three viruses:

- the hepatitis A virus
- the hepatitis B virus
- the hepatitis C virus

In some rare cases, the Epstein Barr Virus (which causes mononucleosis) can also result in hepatitis because it can cause inflammation of the liver. Other viruses and bacteria that can also cause hepatitis include hepatitis D and E, varicella-zoster (chickenpox), and cytomegalovirus (CMV).

Hepatitis A

In children, the most common form of hepatitis is hepatitis A (also called infectious hepatitis), caused by the hepatitis A virus (HAV), which lives in the stools (feces) of infected individu-

als. Infected stool can be present in small amounts in food and on objects (from doorknobs to diapers).

The spread of hepatitis A virus can occur when:

- someone ingests anything that's contaminated with HAV-infected stool (this makes it easy for the virus to spread in overcrowded, unsanitary living conditions);
- found in water, milk, and foods, especially in shellfish.

Because hepatitis A can be a mild infection, particularly in children, it's possible for some people to be unaware that they have had the illness. In fact, although medical tests show that about 40% of urban Americans have had hepatitis A, only about 5% recall being sick. Although the hepatitis A virus can cause prolonged illness up to 6 months, it typically only causes short-lived illnesses and it does not cause chronic liver disease.

Hepatitis B

Hepatitis B (also called serum hepatitis) is caused by the hepatitis B virus (HBV). HBV can cause a wide spectrum of symptoms ranging from general malaise to chronic liver disease that can lead to liver cancer.

The hepatitis B virus spreads through:

- infected body fluids, such as blood, saliva, semen, vaginal fluids, tears, and urine
- a contaminated blood transfusion (uncommon in the United States)
- shared contaminated needles or syringes for injecting drugs
- sexual activity with an HBV-infected person
- transmission from HBV-infected mothers to their newborn babies.

Hepatitis C

The spread of hepatitis C virus (HCV) can occur by direct contact with an infected person's blood. The symptoms of the hepatitis C virus can be very similar to those of the hepatitis A and B viruses. However, infection with the hepatitis C virus can lead to chronic liver disease and is the leading reason for liver transplant in the United States.

The Hepatitis C virus spreads by:

- sharing drug needles
- getting a tattoo or body piercing with unsterilized tools
- blood transfusions (especially ones that occurred before 1992; since then the U.S. blood supply has been routinely screened for the disease)
- transmission from mother to newborn
- sexual contact (although this is less common).

Hepatitis C is also a common threat in kidney dialysis centers. Rarely, people living with an infected person can contract the disease by sharing items that might contain that person's blood, such as razors or toothbrushes.

Diagnosis

All of these viral hepatitis conditions can be diagnosed and treated readily by receiving available blood tests.

Signs and Symptoms

Hepatitis, in its early stages, may cause flu-like symptoms, including:

- **malaise (a general ill feeling)**
- **fever**
- **muscle aches**
- **loss of appetite**
- **nausea**
- **vomiting**
- **diarrhea**
- **jaundice *(a yellowing of the skin and whites of the eye)***

Some people with hepatitis may have no symptoms at all and may not even know they're infected. Children with hepatitis A, for example, usually have mild symptoms or have no symptoms at all.

If hepatitis progresses its symptoms begin to point to the liver as the source of illness. Chemicals normally secreted by the liver begin to build up in the blood, which causes:

- **jaundice**
- **foul breath**
- **a bitter taste in the mouth**
- **dark or "tea-colored" urine**
- **white, light, or "clay-colored" stools**

There can also be abdominal pain, which may be centered below the right ribs (over a tender, swollen liver) or below the left ribs (over a tender spleen).

Contagiousness

Hepatitis A, hepatitis B, and hepatitis C are all contagious.

The hepatitis A virus spreads in contaminated food or water, as well as in unsanitary conditions in child-care facilities or schools. Toilets and sinks used by an infected person should be cleaned with antiseptic cleansers. People who live with or care for someone with hepatitis should wash their hands after contact with the infected person. In addition, when traveling to countries where hepatitis A is prevalent, your child should be vaccinated with at least two doses of the hepatitis A vaccine.

The hepatitis B virus can be found in virtually all body fluids, though its main routes of infection are through sexual contact, contaminated blood transfusions, and shared needles for drug injections. Household contact with adults with hepatitis B can put people at risk for contracting hepatitis. However, frequent hand washing and good hygiene practices can reduce this risk. All children in the United States are routinely vaccinated against hepatitis B at birth and use of the hepatitis B vaccine can greatly decrease the incidence of this infection. Ask your child's doctor about this vaccine. Even adults can be vaccinated if they feel they are at risk.

The hepatitis C virus spreads through shared drug needles, contaminated blood products, and, less commonly, through sexual contact. Although hepatitis C can be spread from a mother to her

fetus during pregnancy, the risk of passing hepatitis C to the fetus is not very high (about 5%). If you are pregnant, contact your doctor if you think you may have been exposed to hepatitis C.

Over the past several years, improved medical technology has almost eliminated the risk of catching hepatitis from contaminated blood products and blood transfusions. But, as tattoos and acupuncture have become more popular, the risk of developing hepatitis from improperly sterilized equipment used in these procedures has increased. Shared needles in drug use and shared straws in cocaine use are two very common ways for hepatitis C to spread.

Prevention

In general, to prevent viral hepatitis you should:

- Follow good hygiene and avoid crowded, unhealthy living conditions.
- Take extra care, particularly when drinking and swimming, if you travel to areas of the world where sanitation is poor and water quality is uncertain.
- Never eat shellfish from waters contaminated by sewage.
- Remind everyone in your family to wash hands thoroughly after using the toilet and before eating.
- Use antiseptic cleansers to clean any toilet, sink, potty-chair, or bedpan used by someone in the family who develops hepatitis.

Because contaminated needles and syringes are a major source of hepatitis infection, it is a good idea to encourage drug awareness programs in your community and schools. At home, speak to your child frankly and frequently about the dangers of drug use. It is also important to encourage abstinence and safe sex for teens, in order to eliminate their risk of hepatitis infection through sexual contact.

A Hepatitis A vaccine is available and is especially recommended for those who:

- travel abroad
- have other forms of liver disease
- have many sexual partners
- are in high-risk occupations, such as health-care and child-care personnel

If you are planning to travel abroad, consult your doctor in advance so you and your family have enough time to complete the required immunizations. The vaccine is especially useful for staff of child-care facilities or schools where they may be at risk of exposure.

There is also a hepatitis B vaccine that should be given to both children and adults as part of routine immunization. Unfortunately, there is no vaccine for hepatitis C—animal studies indicate that it may not be possible because the virus doesn't cause the kind of response that would be needed for a vaccine to be successful.

Duration

For viral hepatitis, the incubation period (the time it takes for a person to become infected after being exposed) varies depending on which hepatitis virus causes the disease:

- For hepatitis A, the incubation period is 2 to 6 weeks.
- For hepatitis B, the incubation period is between 4 and 20 weeks.
- For hepatitis C, it is estimated that the incubation period is 2 to 26 weeks.

Hepatitis A is usually active for a short time period and once a person recovers, he or she can no longer pass the virus to other people. It is practically unheard for people to become chronic carriers of hepatitis A. Almost all previously healthy persons who develop hepatitis A will completely recover from their illness in a few weeks or months without long-term complications.

With hepatitis B, 85% to 90% of patients recover from their illness completely within 6 months, without long-term complications.

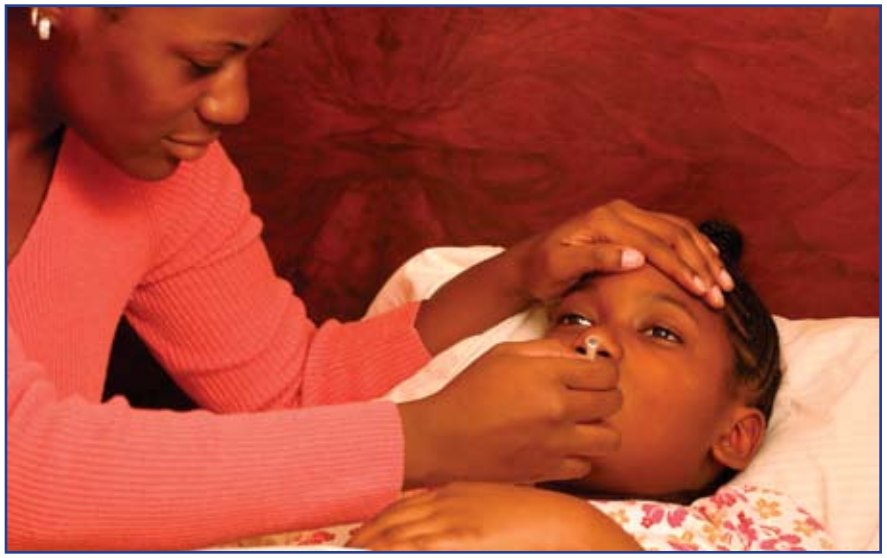
However, 75% to 85% of those who are infected with hepatitis C do not recover completely and are more likely to continue to have a long-term infection. People with hepatitis B (the percentage who do not recover completely) or hepatitis C who continue to be infected can go on to develop chronic hepatitis and cirrhosis of the liver (the chronic degeneration and disruption of the structure of the liver). Some people with hepatitis B or C may also become lifelong carriers of these viruses and can spread them to other people.

Treatment

When symptoms are severe or laboratory tests show liver damage, it is sometimes necessary for hepatitis to be treated in the hospital. Treatments available for the various hepatitis viruses are:

- There are no medications used to treat hepatitis A because it is a short-term infection that goes away on its own.
- Hepatitis B can sometimes be treated using medications. Four drugs are approved for use in adults with hepatitis B, but there has not been enough research yet on their use in children. However, you can talk to your child's doctor about a drug that may be available in some centers on a research basis for children.
- The treatment of hepatitis C has improved significantly with the use of two medications, only one of which is approved for use in children. Another more effective drug is not approved for children yet but is available for kids in some centers on a research basis. In those adults who have just been infected with hepatitis C (by accidental needle injury, for example), combination therapy with the two drugs is the treatment of choice and can eliminate the virus in about 50% of the people infected.

Children with mild hepatitis may be treated at home. Except for using the bathroom, they should rest in bed until the fever and jaundice are gone and their appetite is normal. Kids with a lack of appetite should try smaller, more frequent meals and fluids that are high in calories (like milkshakes). They should also eat healthy foods rich in protein and carbohydrates and drink plenty of water.



When to Call Your Child's Doctor

When to Call Your Child's Doctor

Call the doctor if your child:

- has symptoms of hepatitis
- attends a school or child-care facility where someone has hepatitis
- has been exposed to a friend or relative with the illness

If you have an older child who volunteers at a first-aid station, hospital, or nursing home, be sure that he or she is aware of proper safety procedures for preventing contact with blood or body fluids. You may also want to have your child immunized against the hepatitis B virus. Call your child's doctor if you believe your child may have been exposed to a patient with hepatitis.

If you already know your child has hepatitis, call your child's doctor if you notice any of the following symptoms, which may be signs of their liver condition worsening:

- confusion or extreme drowsiness
- skin rash
- itching

Also, monitor your child's appetite and digestive functions, and call the doctor if your child's appetite decreases, or if nausea, vomiting, diarrhea, or jaundice increase.

Bedwetting (Enuresis)[15]

Most doctors consider a bedwetting child to be any girl older than age four and any boy over age five who wets the bed. Bedwetting generally declines with age. About 10% of all 6 year olds and about 3% of all 14 year olds wet the bed. In a very small number of cases, bedwetting can continue into adulthood. PRIMARY Enuresis refers to the child who has never been or is only occasionally dry at night. SECONDARY enuresis refers to bedwetting episodes that occur after a child has been dry at night for a considerable length of time.

Primary Enuresis

Current thought regarding chronic bedwetting is related to (1) a physically and/or neurologically immature bladder and /or (2) a deep sleeping pattern. Apparently, these children often sleep so deeply that they are unaware of the message the bladder sends to the brain saying it is full. It is presumed that bedwetting is an inherited condition.

Secondary Enuresis

Children who have been dry at night for a considerable period of time may have occasional episodes of bedwetting. These are usually related to stresses in the child's life and clear up on

their own. Three of the more common events likely to cause bedwetting in young children are: Hospitalization, entering school, and the birth of a sibling. Children can also experience stress from such family problems as divorce, parental alcoholism, domestic violence, and abuse or neglect, all of which make foster children prime candidates. If the condition persists, it is best to consult the child's doctor.

Effects of Primary Enuresis on the child and family

By the first grade, most children are embarrassed by their bedwetting and avoid social activities that require sleeping away from home. They often suffer from low self-image and their feelings can be even more affected by the attitudes of their caregivers, who may feel their efforts to end the bedwetting have failed and be frustrated, angry, and embarrassed by their child's condition. Caregivers can help their child reduce negative feelings and speed up the process of overcoming it by offering positive support, understanding and encouragement.

Treatment

Almost all children outgrow their bedwetting, but when this does not happen, there are two approaches to treatment: Medical or Behavioral. Behavioral treatment is often more effective and is safer than medical treatment. While it may take somewhat longer to show results, the improvement usually continues indefinitely. Below are several behavioral methods that may be helpful:

- Retention control training—The child is asked to control urination during the day by postponing it, first for a few minutes and then gradually longer. This can extend the capacity of the bladder and strengthen the muscle that holds back urination.
- Night Lifting—This involves waking the child periodically, walking the child to the bathroom and then returning the child to bed. By teaching the child to awaken and empty the bladder, it is hoped that the child will eventually stay dry.
- Moisture Alarm—An alarm consists of a clip-on sensor that attaches to the outside of the bed clothing. The alarm is set off when the child begins to wet the bed. It wakes the child, who will then go to the bathroom to finish, then go back to sleep. This slowly conditions the brain to respond appropriately during sleep to messages from the bladder. This treatment may take many weeks or even several months to work but it has good long-term success and fewer relapses than medications.

Sickle-Cell Anemia[16]

This disease is an inherited blood disorder that occurs often in African Americans but may be found in Africans, Arabs, Greeks, Italians, Latin Americans, Indians, and even Caucasians. It is caused by an abnormality in the pigment hemoglobin, the oxygen-carrying component of the red blood cells. The defective hemoglobin causes the red blood cells to become rigid and "sickle" shaped (hard and pointed like the implement used to cut weeds and tall grass) instead of flexible and round. These deformed cells are brittle and easily destroyed, leading to the symptoms of sickle-cell disease. Although the abnormal hemoglobin can be detected at birth, symptoms generally do not appear until the infant is about 6 months old. These symptoms include delayed growth and development and anemia, that causes fatigue, pallor, and

increased susceptibility to infection. The first noticeable sign of the disease may be a painful attack known as a sickle-cell crisis. Such an episode often follows an infection or injury and affects various parts of the body, particularly the abdomen, long bones, joints and chest. Vision problems can occur when the retina is affected. The severity and frequency of crises can vary tremendously.

Treatment

There is no cure for sickle-cell anemia, but with the doctor's help, the discomfort of most crises can be eased and others prevented. Moderate crises can be managed with medication to relieve pain and prevent dehydration. During more severe crises, oxygen may be given if the child's blood does not have enough. A blood transfusion before any medical or dental surgery can provide the child with healthy red blood cells, thus avoiding the crisis that might otherwise follow.

Coping with Sickle-Cell Anemia:

- Make sure the child receives all appropriate vaccines to prevent infections.
- Watch for infections and administer antibiotics promptly as prescribed by the child's doctor.
- Talk to the doctor about treating the child with antibiotics in advance to prevent serious infections.
- Give the child daily oral supplements of folic acid because the disease increases the body's need for this vitamin.
- Make sure the child drinks plenty of water daily, avoids too hot or cold temperatures, avoids overexertion and stress, and gets plenty of rest.
- Take appropriate precautions when traveling in airplanes or to high altitudes. (The body normally compensates for reduced oxygen due to high altitudes and changing air pressure in airplanes by increasing the amount of circulating red blood cells and hemoglobin. However, in a child with sickle-cell anemia, this could lead to an increase in abnormal hemoglobin and precipitate a sickle-cell crisis.)

Autism[17]

Autism is not a disease, but a developmental disorder of brain function. People with classic autism show three types of symptoms: Impaired social interaction, problems with verbal and nonverbal communication and imagination, and unusual or severely limited activities and interests. Symptoms usually appear during the first three years of childhood and continue throughout life. Although there is no cure, appropriate management may foster relatively normal development and reduce undesirable behaviors. Autism strikes males more often than females, and has been found throughout the world in people of all racial and social backgrounds.

Autism varies greatly in severity. The most severe cases are marked by extremely repetitive, unusual, self-injurious, and aggressive behavior. This behavior may persist over time and prove very difficult to change, posing a tremendous challenge to those who must live with, treat, and teach these individuals. The mildest forms of autism resemble a personality disorder associated with a perceived learning disability.

The hallmark feature of autism is impaired social interaction. Children with autism may fail to respond to their names and often avoid looking at other people. Such children often have difficulty interpreting tone of voice or facial expressions and do not respond to others' emotions or watch other people's faces for cues about appropriate behavior.

People with autism often have abnormal responses to sounds, touch, or other sensory stimulation. Many show reduced sensitivity to pain. They also may be extraordinarily sensitive to other sensations. These unusual sensitivities may contribute to behavioral symptoms such as resistance to being cuddled.

Symptoms in many children with autism improve with interventions or as the children mature. Interventions may be either educational/behavioral or medical, and are usually a combination of both:

- Educational/behavioral interventions emphasize highly structured and often intensive skill-oriented training. Because children learn most effectively and rapidly when very young, this type of therapy should begin as early as possible.
- Medical interventions are a variety of drugs that reduce self-injurious behavior or other troublesome symptoms as well as associated conditions such as epilepsy and attention disorders.

Some people with autism eventually lead normal or near-normal lives. However, reports from parents of children with autism indicate that some children's language skills regress early in life, usually before age three. This regression often seems linked to epilepsy or seizure-like brain activity. Adolescence also worsens behavior problems in some children with autism who may become depressed or increasingly unmanageable. Caregivers should be ready to adjust treatment for their child's changing needs.

Depression

Depression is a common and serious form of childhood mental disorder. Until as recently as the 1980s, doctors and others rarely considered that children could become depressed, however, research has shown that they do, suffering many of the same symptoms that are seen in adults with a major depression, but also some that are unique to their age. When recognized early and diagnosed accurately, depression is highly responsive to treatment

Several forms of depression affect children and adults alike. Major depression is characterized by specific signs and symptoms. In children, doctors are learning, these classic symptoms often may be obscured by other behavioral and physical complaints—features such as those bracketed. At least five symptoms must be present to the extent that they interfere with daily functioning over a minimal period of two weeks.

Signs and Symptoms of Depression (As seen often in children and adolescents):

- Frequent sadness, tearfulness, crying
  Increased irritability, anger, or hostility
- Hopelessness
- Preoccupation with nihilistic song lyrics

- Decreased interest or enjoyment in once-favorite activities
- Low energy
- Persistent boredom
- Frequent complaints of physical illness; for example, headache, stomachache
- Poor communication with family and friends, social isolation
- Low self-esteem, feelings of guilt
- Oppositional; negative
- Extreme sensitivity to rejection or failure
- Inability to concentrate *(poor performance in school; frequent absences)*
- Changes in sleep habits *(Excessive late-night TV; refusal to wake in the morning)*
- Changes in eating habits *(Failure to gain weight as normally expected; bulimia or anorexia)*
- Talk of running away from home or efforts to do so
- Thoughts or expressions of suicide or self-destructive behavior

Less frequently seen in children is bipolar depression, a phase of manic depressive, or bipolar disorder, in which periods of depression alternate with periods of unnaturally high levels of energy and grandiosity.

A child's pediatrician or other primary health care provider as well as schoolteachers and counselors are key sources for potentially recognizing mental disorders in children and adolescents.

Child Development Institute. ***http://www.cdipage.com***

Attention Deficit Hyperactivity Disorder (ADD/ADHD)[18]

Some children have more trouble paying attention in school and completing assignments than others. It is estimated that from 3 to 10 percent of the population has a condition known as Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD). This disorder is said to be found present more often in boys than girls (3:1). Not every student having trouble completing assignments or who is squirmy and disruptive to the class has ADD.

This is particularly true in the lower grades where many of the students have not reached a level of maturity sufficient to meet the demands of the classroom. Some studies have found that a first grade teacher may rate as many as 50% of the boys in the class as having ADD using common clinical questionnaires. Thus, educators may mislabel behavior as being abnormal when it actually may be within the low end of normal development.

There are a variety of causes for poor attention, concentration and impulse control. A partial list would include the following:

- Immaturity and slow psychological development
- Learning disabilities such as dyslexia
- Anxiety
- Low Thyroid function
- Low motivation
- Lack of sufficient sleep
- Poor nutrition, and
- Boredom due to lack of challenge

Children who have experienced abuse and/or neglect are highly at risk for many of these.

Suggestions for parenting children who exhibit disorders:

- **Organize your schedule at home.** Set up specific times for waking, eating, playing, doing homework, doing chores, watching TV and going to bed. Write the schedule on a blackboard or paper and hang it where the child will always see it. If the child can't read yet, use drawings to show the activities. Explain any changes and make sure the child understands those.
- **Set up house rules.** Make the rules for the family simple, clear and short. Explain them clearly as well as what will happen when the rules are obeyed and when they are broken. Hang this list next to the schedule. The punishment for breaking rules should be fair, quick and consistent.
- **Be positive.** Tell the child what you want rather than what you don't want. Reward the child regularly for any good behavior, even little things such as getting dressed or closing the door quietly.
- **Make sure directions are understood.** First, get your child's attention. Look directly into the child's eyes then tell the child in a clear, calm voice specifically what you want. Ask the child to repeat the directions back to you. Keep directions simple and short. For difficult tasks, give only one or two directions at a time, then congratulate the child when he or she completes each step.
- **Be consistent:** Do what you say you are going to do. When the child breaks the rules, warn them only once in a quiet voice. If the warning does not work, follow through with the punishment you promised.
- **Make sure someone watches your child all the time.** Because they are impulsive, children with ADHD need more adult supervision than other children their age. Make sure your child is supervised by adults all day.
- **Watch your child around his friends.** It's hard for children with ADHD to learn social skills and social rules. Invite only one or two friends at a time to play; watch them closely and reward good play behaviors.
- **Help with school activities.** Get ready the night before and allow enough time for the child to get dressed and eat a good breakfast.

- Set up homework routines. Pick a regular place for doing homework, away from distractions such as other people, or television. Break the time into small parts and have breaks.
- Focus on effort, not grades. Reward your child when he tries to finish schoolwork, not just for good grades. You can give extra rewards for earning better grades.

HIV and AIDS

HIV is a viral infection that causes a chronic life-threatening condition called acquired immune deficiency syndrome (AIDS). AIDS occurs when the HIV infection damages or destroys the cells of the immune system, reducing the body's ability to fight off bacterial, viral or fungal infections. As the immune system fails, the person becomes vulnerable to illnesses they would normally resist, including infections such as pneumonia, meningitis, intestinal infections and certain types of cancers.

HIV can affect people of all genders, races and ages. In the majority of cases of children with HIV, the virus is transmitted from the mother during pregnancy, delivery or through breast milk.

There appear to be two general patterns of illness in HIV-infected children. About 20% develop serious disease in the first year of life and most of these children die by the age of four. In the remaining 80%, the disease progresses more slowly, especially with infants who are generally placed on a medication program after birth. An HIV-positive child often fails to gain weight and doesn't grow properly. They may develop problems with walking or show delayed mental development. They may also develop cerebral palsy. Like adults, the children are vulnerable to opportunistic infections and normal childhood infections can be severe. Swollen lymph glands may be the first sign of AIDS. Other symptoms may include:

Weight loss
Diarrhea
Fever
Cough
Weakness
Shortness of breath
Headaches
Night sweats
Visual problems
Dementia
Development of a variety of cancers

If untreated, these problems and related complications may be rapidly fatal.[19]

UNIVERSAL PRECAUTIONS

These are infection control measures taken by health care workers with all persons, regardless of their HIV status. Universal precautions consist of the use of appropriate barrier precautions (usually gloves) to prevent direct contact with blood, semen, vaginal secretions, visibly bloody body fluids, or other special fluids such as spinal fluid, which contain large amounts of HIV.

In the family, school, or home setting, the primary risk of HIV transmission occurs from exposure to blood. Body fluids of affected infants or children such as tears, saliva, urine, feces, vomit, and nasal secretions, if not visibly contaminated with blood, are not infectious and gloves or other barrier precautions are not necessary for routine child care, including diapering/toileting, feeding or burping. These same body fluids, if visibly contaminated with blood, are potentially infectious, and universal precautions should be used. In homes, HIV is readily killed by the

level of heat achievable in dishwashers and clothes dryers. In addition, a solution of one part bleach and 10 parts water is inexpensive and effective on hard surfaces (solution loses its effectiveness after 24 hours and must be changed). If blood is on a rug or upholstery, most commercial cleansers or disinfectants will eradicate the virus. In any case, HIV does not survive for prolonged periods outside the body. Dried blood and other stains of uncertain origin need not be considered infectious.

A special

"Thank you"

goes out to you from the foster children of Indiana and from the staff of the Indiana Department of Child Services.

About DCS Toll Free Numbers

For quick access to information about various programs and services, call these numbers—toll-free!

Child Abuse Hotline
1-800-800-5556

Missing Children
1-800-831-8953 (State Police)

Child Support Bureau
1-800-840-8757

State Institutional Child Protection
1-800-562-2407

Family Help-Line
1-800-433-0746

State Information Center
1-800-457-8283

Family Support Services
1-800-622-4932

This is a partial directory of DCS's central office in downtown Indianapolis, Indiana.
Correspondence may be sent to:

Indiana Department of Child Services
302 W. Washington Street, E306, MS47
Indianapolis, IN 46204

General Information:
(317) 232-4705
FAX: (317) 232-4490

Report Abuse and Neglect:
(800) 800-5556

Child Support Hotline:
(800) 840-8757

UNLESS OTHERWISE NOTED, ALL AREA CODES = 317

Indiana Department of Child Services and
Division of Family Resources local office phone directory

Footnotes

1 *Reprinted from* ***Children Today****—U. S. Department of Health and Human Services*

2 *Reprinted from the* ***Iowa Foster Parent Manual***

3 *Reprinted from the* ***Iowa Foster Parent Manual****.*

4 *Reprinted from* ***New York State Foster Parent Manual***

5 *Based on material from Susan B. Edelstein and the Child Welfare League of America Practice Forum*

6 *In. Chapter of the National Committee for Prevention of Child Abuse. Adapted from Southern Nevada Chapter NCPCA*

7 *National Highway Traffic Safety Administration (NHTSA) Website:* ***www.nhtsa.gov***

9 *Reprinted from* ***Pre-Service Training Guide, Institute for Human Services****, 1998*

10 *Taken from* ***Child Development, Session IV of Pre-service training for Foster, Adoptive, Kinship Parents/Caregivers****; Institute for Human Services.*

11 *Reprinted from the* ***Illinois Department of Children and Family Services Foster Parent Handbook****.*

12 *Reprinted from:* ***Focus Adult Services****,* ***www.focusas.com***

13 *Mayo Clinic:* ***Tools for Healthier Lives****.* ***www.mayoclinic.com/health/fetal-alcohol-syndrome****.*

14 *Reprinted from* ***http://www.kidshealth.org/parent/infections/bacterial_viral/hepatitis.html****.*

15 *Child Development Institute.* ***www.childdevelopmentinfo.com/disorders/bedwetting.shtml****.*

16 *Excerpt from* ***The Disney Encyclopedia of Baby & Child Care****, 1995 DSH Communications, Inc.*

17 *Child Development Institute.* ***www.childdevelopmentinfo.com/disorders/autism-fact-sheet.shtml****.*

18 *Child Development Institute.* ***www.childdevelopmentinfo.com/disorders/adhd.shtml****.*

19 *BBC Health.* ***www.bbc.co.uk/health/conditions/hiv2.shtml***